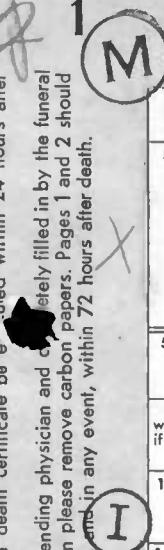


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6341

CERTIFICATE OF DEATH

06326

1. NAME OF DECEASED
(Type or Print)

Lola Florence Al. ff

2. DATE OF DEATH

6/15/61

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

James Howard County
Brooklyn - 25
5320 Brookwood Rd. A. A Co.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY An. Hr. Co.

C. CITY OR TOWN Brooklyn

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

5320 Brookwood Rd

(If rural, give location)

5. SEX

6. COLOR OR RACE

Female W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Wid

8. DATE OF BIRTH

5/20/87

9. AGE (In years
last birthday)

74

If Under 1 Year

Months Days Hours Min.

10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Witt

14. MOTHER'S MAIDEN NAME

Lucy Cox

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

**DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH**

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) _____

DUE TO _____

coronary occlusion
cardio-

(B) _____

DUE TO _____

hypertensive vascular
disease

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

I CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART FOR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES - NO

22. I certify that (I) (this hospital) attended the deceased from

6/15 1961 that (I) (we) last saw the deceased alive on 6/30 1961 and that in (my) (our) opinion death occurred at 6/15 1961 p.m., from the causes and on the date stated above.

23a. SIGNATURE

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

23b. ADDRESS

302 Patapsco Av

23c. DATE SIGNED

6-16-61

24a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24b. DATE

6/19/61

24c. NAME OF CEMETERY OR CREMATORIUM

Loudon Pk.

24d. LOCATION

(City, town, or county)

(State)

Balto., Md.

25a. DATE REC'D BY HEALTH DEPT.

JUN 19 '61

25b. NAME OF REGISTRAR

Arthur S. Krause

25c. FUNERAL DIRECTOR

McCullly Funeral Hms. 130 E. Fort Ave. jhh

8500

M

STATE OF NEW YORK
DEPARTMENT OF MOTOR VEHICLES
REGISTRATION CARD

REGISTRATION
NUMBER
111000000000000000

NAME OF OWNER AND ADDRESS WHERE OWNED AND DATE OF BIRTHDAY

NAME OF OWNER
ADDRESS

NAME OF OWNER
ADDRESS

OWNER'S
NAME
AND
ADDRESS
 C.R.
 T.P.

OWNER'S
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FOR STATE
HEALTH DEPT.

tems 18-21 Film 290 7-13-61 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06327

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft. George C. Meade		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GRACE	Middle ELLEN	Last ANDERSON
4. DATE OF DEATH	Month June	Day 27	Year 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Retired Major George S. Anderson (husband)
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 888.9 Ingestion of meprobamate and alcohol DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of meprobamate and alcohol	
20c. TIME OF INJURY Month, Day, Year Hour o.m. Unknown p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown
20f. (City or town) Unknown		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Unknown	DATE SIGNED 6/28/61
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-61	22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven
22d. LOCATION (City, town, or country) Glen Burnie		(State)	
23. FUNERAL DIRECTOR Hopping & MIRKLE, Glen Burnie		24a. REC'D BY REGISTRAR Date 3 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06328

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Coopersville

c. LENGTH OF STAY IN 1b

10 yr., 1 mo.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Crownsville State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

John Farrow Anderson

4. DATE
OF
DEATH

6 3

1961

Day Month Year

5. SEX

Male C

6. COLOR OR RACE

WIDOWED DIVORCED 7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

6-15-1894

9. AGE (In years
last birthday)

66 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chemical operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

Prince Edw. Co., Va. USA

13. FATHER'S NAME

unknown

John Frank Anderson

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank, dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

medical records. CSH.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

715X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

Dehydration

DUE TO

Infection - decubitus ulcers, Hypostatic pneumonia

(c)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5-7-1951 to 6-3-1961, that (I) (we) last saw the deceased alive on June 3, 1961, and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE

Enrique J. del Campo M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

6-3-61

22c. PHYSICIAN'S
NAME (Type)

Enrique J. del Campo

22d. ADDRESS

Crownsville State Hospital, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial June 7/61

23c. NAME OF CEMETERY OR CREMATORIUM

Mt Calvary Cem.

23d. LOCATION (City, town or county)

A.A. County Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Morton E. Elicker

ADDRESS

1129 h. Caroline St.
ATE JUN 9 '61

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Turner

22830

M

W. & C. 1927 - 1928

united States note

10

dated April 1st 1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6344

CERTIFICATE OF DEATH

Item 8 Film G240 7/6/61 i wk

06329

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis		e. STATE Maryland b. COUNTY Anne Arundel			
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
				Odenton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Anne Arundel General Hospital		d. STREET ADDRESS			
First		Middle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Walter		W.		Fourth Avenue, Box 335			
Last		4. DATE OF DEATH		Month Day Year			
Asbury SR		June 27		19 61			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH			
		NAT'L Plastic		12-16-1911			
				5. (in years) IF UNDER 1 YEAR birthday Months Days Hours Min.			
				Kentucky 12/11/49 yrs.			
11. BIRTHPLACE (Country or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Kentucky		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
James Asbury		Millie Farmer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT			
No		232-16-5891		Walter W Asbury, Jr., same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 days.					
Pneumonia							
162.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)							
Branchial carcinoma							
DUE TO (c)		1 year.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) March	(County) 1961	(State) to 6/21, 1961
21. I certify that (I) (this hospital) attended the deceased from.....		1961 to 6/21, 1961; that (I) (we) last saw the deceased alive on.....				22b. DATE SIGNED	
G/27 1961		and that death occurred at 1:05 P.M. on the causes and on the date stated above.					
22a. SIGNATURE Gerard Church		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gerard Church		22d. ADDRESS Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF JUN 30 61		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven		23d. LOCATION (City, town or county) Glen Burnie, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKLEY		ADDRESS J. Kirkley		25e. REC'D BY REGISTRAR DATE JUL 3 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6345

CERTIFICATE OF DEATH

06330

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Ruxton Road	
3. NAME OF DECEASED (Type or print) Walter		First E.	Middle ATKINSON
4. DATE OF DEATH June 3 1961		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1909	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY Stereotyper	
11. BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Williams N. Atkinson		14. MOTHER'S MAIDEN NAME Georgina E. Lower	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 17. INFORMANT Dorothy C. Atkinson ②	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 433 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) atrio-ventricular fibrillation - flutter (c) atrio-ventricular conduction		INTERVAL BETWEEN ONSET AND DEATH 6 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) —	
		(State) —	
21. I certify that (I) Frank M. Shipley attended the deceased from May 23, 1961 to June 3, 1961 , that (I) Frank M. Shipley last saw the deceased alive on June 3, 1961 , and that death occurred at M. from the causes and on the date stated above.		22a. SIGNATURE Frank M. Shipley	
		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-1961	23c. NAME OF CEMETERY OR CREMATORIAL Parkside and West Peabody Mass.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		ADDRESS Annapolis Md	25a. REC'D BY REGISTRAR DATE JUN 7 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Krause

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fehlerfrei weiß

M

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ab 100m²

bedr. nocturni

Entwurf Lutz und fehlerfrei

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ENTWURF

fehlerfrei

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entwurf

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entwurf

fehlerfrei

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entwurf fehlerfrei 100

fehlerfrei 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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X
I
O
/

6346

1

1. PLACE OF DEATH

a. COUNTY Anne Arundel MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

c. LENGTH OF STAY IN 1b
RURAL

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION 16 N. LINDEN AVE.

3. NAME OF
DECEASED
(Type or print)

SUSIE

First

M.

Middle

BARNES

Last

4. DATE
OF
DEATH

8

Month

11

Day

1961

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

12-20-1889

9. AGE (In years
last birthday)

71 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

GEORGE J. SCHAEFFER

14. MOTHER'S MAIDEN NAME

ELIZ ANN DOXZEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

—

16. SOCIAL SECURITY NO.

—

17. INFORMANT

JAMES W. BARNES #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

{

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

{

(c)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Anticoagulant C.V. Glaxo

4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.

20d. INJURY OCCURRED
While Nat while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1961 to Jan 11, 1965, that (I) (we) last saw the deceased alive on Jan 11, 1965, and that death occurred at 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

Maurice Klawans,
Maurice E. Klawans,

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
6/2/64

22c. PHYSICIAN'S
NAME (Type)

MAURICE E. KLAWANS

22d. ADDRESS

31 Southgate Inn.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

6-14-64

23c. NAME OF CEMETERY OR CREMATORIAL

ASBURY

23d. LOCATION (City, town, or county)

ARNOLD

(State)
MD

24. FUNERAL DIRECTOR'S SIGNATURE

John M. O'Farrell Annapolis, Md.

ADDRESS

—

25a. REC'D BY REGISTRAR

JUN 19 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

18530

18530 TRADEMARK

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6347

Item 5, telephone call - McCully Funeral Home - 6/13/61

Reg. Dist. No.

06332

1. PLACE OF DEATH a. COUNTY <i>AH</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>QA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Arnold - Shore Acres</i>		d. STREET ADDRESS <i>Shore acres</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shore acres</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Anna</i>		First	Middle <i>R.</i>	Last <i>Beall</i>	4. DATE OF DEATH <i>Oct 9, 1889</i>	Month <i>6</i>	Day <i>10</i>	Year <i>1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 9, 1889</i>		9. AGE (In years from birthday) yrs. <i>71</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Off</i>		11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>			
13. FATHER'S NAME <i>Thomas Steadman</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ann</i>		Address <i>None</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Famly</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>593X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Hemorrhage</i> (c) <i>Hypertension - Molaritic Origin</i>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Anæmia</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>An Arnold - Maryland</i>		(County) <i>Anne Arundel</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>May 16, 1961</i> , to <i>June 8, 1961</i> , that I last saw the deceased alive on <i>June 8, 1961</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. Arnold - Maryland</i>							DATE SIGNED
ACTUAL SIGNATURE <i>Thomas G. Deane</i>									
PHYSICIAN'S NAME (Type) <i>Thomas G. Deane</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3</i>		22b. DATE THEREOF <i>6-14-61</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home</i>		ADDRESS <i>130 E. Fort Ave</i>		24a. REC'D BY REGISTRAR <i>John S. Thomas</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>			
				DATE JUN 13 '61					

WISCONSIN STATE DEPARTMENT OF HEALTH—VOLUME 18

44-203

CERTIFICATE OF DEATH



NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH	NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL DIRECTOR	NAME OF CEMETERY
John Doe	55	M	Heart Disease	10:00 AM	Hospital	Dr. Smith	General Hospital	Funeral Home	Local Cemetery
Jane Doe	50	F	Cancer	11:00 AM	Hospital	Dr. Johnson	General Hospital	Funeral Home	Local Cemetery
John Doe Jr.	25	M	Accident	12:00 PM	Hospital	Dr. Williams	General Hospital	Funeral Home	Local Cemetery
Jane Doe Jr.	20	F	Stroke	1:00 PM	Hospital	Dr. Brown	General Hospital	Funeral Home	Local Cemetery

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06333

1. PLACE OF DEATH

e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Glen Burnie

c. LENGTH OF STAY IN 1b

1yr.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1029 Sharon Drive - Fairway Gardens

3. NAME OF
DECEASED
(Type or print)

First

Middle

Beck

5. SEX

6. COLOR OR RACE

Male

White

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician (ret.)

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

21st July 1894

9. AGE (In years last birthday)

66 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

13. FATHER'S NAME

Joseph S. Beck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank & date of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

11. BIRTHPLACE (County & State, or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mattie Marshall

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Unknown Mrs. Ruby Osborne

Same As #1

Congestive Heart Failure

Myocardial Infarction

Coronary Artery Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

2 months

7 months

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

2d. INJURY OCCURRED

While at work Not While at work at work at work

2d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2d. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

July 1960

to July 24th

1961

that (I) () last

saw the deceased alive on

June 20th 1961

6 PM

from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

HILARY T. O'HERLIHY

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.DATE
SIGNED

22d. ADDRESS

5 Central Ave. Glen Burnie Md.

June 24/1961

23e. BURIAL, CREMATION,
REMOVAL (Specify)

Buried

23b. DATE THEREOF

26th June 1961

23c. NAME OF CEMETERY OR CREMATORIAL

Glen Haven Cem.

23d. LOCATION (City, town or county)

(State)

Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

R. V. Singleton, Glen Burnie, Md.

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JUN 28 '61

Cathleen S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M) X (I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7473

CERTIFICATE OF DEATH

Reg. Dist. No.

07463

1. PLACE OF DEATH

a. COUNTY

ANNE ARUNDEL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pasadena -

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Rt. #1-Bld 186 - Sand Bar - Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pasadena - Long Point X

d. STREET ADDRESS

Rt. #1-Bld 186 - Sand Bar - Road 1

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

JUNE

29

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

JUNE - 8 - 1888

9. AGE (In years
lost birthday)

73 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

(Ret.)

J. Dasher Co.

Baltimore, md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown (Dec.)

14. MOTHER'S MAIDEN NAME

Unknown (Dec.)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

213-04-8655 James W. Brown

5302 Baltimore Rd.
Balto. #14, md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY THROMBOSIS

INTERVAL BETWEEN
ONSET AND DEATH

INSTANTANEOUS

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

CORONARY SCLEROSIS

10 YRS.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from JUNE 18, 1961, to JUNE 29, 1961, that I last saw the deceased alive on JUNE 23, 1961, and that death occurred at about 6:00 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

J. Brady Smith

M.D.

8471 Ft. Smallwood Rd. 6/29/61

PHYSICIAN'S
NAME (Type)

J. BRADY SMITH

PASADENA, MD

22o. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial

7-3-1961

22c. NAME OF CEMETERY OR CREMATORIUM

Loudon Park Cemetery

22d. LOCATION (City, town, or county)

Baltimore -

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Signature ~~Robert P. Clare~~ - Glen Burnie, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE JUL 17 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Knob

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
6349 CERTIFICATE OF DEATH																			
Reg. Dist. No. 06334																			
1. PLACE OF DEATH a. COUNTY <i>A.A.C.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				b. COUNTY <i>Aa</i>															
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>502 Hanlin Rd.</i>				d. STREET ADDRESS <i>502 Hanlin Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <i>Adele</i>	Middle <i>S.</i>	Last <i>Bready</i>	4. DATE OF DEATH <i>June 12, 1961</i>	Month 19	Day 12	Year 1961											
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 25, 1879</i>	AGE (In years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR Months <i>82</i>	IF UNDER 24 HRS. Days <i>82</i>	Hours <i>0</i>	Min. <i>0</i>										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Charles A Seim</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Bruce Hoffman</i>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT <i>Mr Frank B Bready 205 Davis St #2</i>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>												<i>sudden</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i>												<i>years</i>							
DUE TO (c) <i>Senility</i>												<i>years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>				20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>				
21. I certify that I attended the deceased from <i>August, 1960</i> , to <i>June, 1961</i> , that I last saw the deceased alive on <i>May, 1961</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <i>425 S. Ritchie Hwy</i>		DATE SIGNED					
ACTUAL SIGNATURE <i>Ernest A Leipold M.D.</i>				22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/14/61</i>								22b. DATE THEREOF <i>6/14/61</i>				22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>London Park</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Am J. Tucker Sons North Penna Ave Belts 17, Md.</i>				24a. REC'D BY REGISTRAR <i>JUN 16 '61</i>								24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>							

CERTIFICATE OF DEATH

HEAD OF FAMILY

NAME

ADDRESS

CITY OR TOWN

COUNTY

STATE

ZIP CODE

ADMISSION
NUMBER

DATE OF DEATH

AGE

SEX

RACE

RELATIONSHIP

TO DECEASED

NAME

10

11/12/72
+
11/12/72
11/12/72

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06335

6350

1. PLACE OF DEATH o. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>702 Severn Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louise</i>	Middle <i>R.</i>	Last <i>Brooks</i>		
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>6-28-1871</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Germany</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Karl Wyler</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <input type="checkbox"/>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>George T. Brooks</i>	Address <i>2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>420.0</i> DUE TO <i>Acute Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>5 yrs.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19 p.m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Md.</i>	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 10 1958</i> to <i>6-23-1961</i> , that (I) (we) last saw the deceased alive on <i>6-23-1961</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Jewell Martin</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6-26-61</i>		
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		22d. ADDRESS <i>ANNAPOLIS, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-26-1961</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Edwards Chapel</i>	23d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	25a. REC'D BY REGISTRAR DATE <i>JUN 27 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6351

CERTIFICATE OF DEATH

06336

1. PLACE OF DEATH

e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

6 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

(Dead on arrival)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Glenn

Tucker

BROWN

5. SEX

6. COLOR OR RACE

Male

White

WIDOWED

NEVER MARRIED MARRIED DIVORCED 7. MARRIED

8. DATE OF BIRTH

Jan. 2, 1961

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

e. IS RESIDENCE
ON A FARM?
YES NO 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Hunt Graham Brown

14. MOTHER'S MAIDEN NAME

Sylvia Anne Dodson

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

(Yes, no, or unknown) (If yes give war or dates of service)

Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

754.5

DUE TO

(b)

Pneumonia, Hemorrhage

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

DUE TO

(c)

Cong. Anesthesia

Congenital Heart Disease Tricuspid Atresia

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY	Month, Day, Year
Hour a.m. p.m.	19
20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
While at work	Not While at work <input type="checkbox"/>
20f. (City or town)	(County)
	(State)

21. I certify that (I) attended the deceased from Jan. 2, 1961 to June 14, 1961, that (I) last saw the deceased alive on June 14, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Clayton Norton

10:35 A.M.

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Clayton Norton

ATTENDING
PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Medical Bldg., Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county) (State)
BURIAL	6-17-61	HILLCREST	Annapolis MD.
FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25e. REC'D BY REGISTRAR	25f. REGISTRAR'S SIGNATURE
Donald J. Norton	Annapolis, Md.	JUN 19 '61	Arthur S. Koenig

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C352

06337

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rehobeth Beach	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 215 Philadelphia St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Adam		4. DATE OF DEATH Last Month Day Year June 19 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bunten		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Annapolis, Md. Mr. John Bunten (son) Cape St. Claire	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Recurrent attacks of coronary thrombosis		8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) DUE TO (b) Recurrent attacks of coronary thrombosis (c) Generalized arterio-sclerosis		15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (REDACTED) attended the deceased from..... June 18, 1961 to..... June 18, 1961, that (I) (REDACTED) last saw the deceased alive on..... June 18, 1961, and that death occurred at..... M, from the causes and on the date stated above.		22b. DATE SIGNED 6/19/61	
22a. SIGNATURE Bertrand C. R. Gau		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Bertrand C. R. Gau		22d. ADDRESS Rt-4, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21st. June '61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glen Haven Cemetery Glen Burnie, Maryland		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. J. Synder		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
		25b. REGISTRAR'S SIGNATURE Charles S. Haas	

- 10 -

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06338

1		C		M		I			
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		6338		06			
1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-3, Box-207				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas		First	Middle	Last	4. DATE OF DEATH COCKRELL	Month June	Day 1	Year 19 61	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	8. DATE OF BIRTH May 31, 1961	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 52	Hours 2	Min 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph Thomas Cockrell, Jr.		14. MOTHER'S MAIDEN NAME Mary Margaret Sweeney							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO <i>Prematurity</i>				INTERVAL BETWEEN ONSET AND DEATH			
{ (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) May 31	(County) 1961	(State) Md.		
21. I certify that (I) (John H. Sims) attended the deceased from May 31, 1961, to May 31, 1961, that (I) (Niel H. Sims) last saw the deceased alive on May 31, 1961, and that death occurred at M, from the causes and on the date stated above.				1:25 A.M.					
22a. SIGNATURE <i>Niel H. Sims</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/61	
22c. PHYSICIAN'S NAME (Type) Niel H. Sims				22d. ADDRESS 95 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/1961		23c. NAME OF CEMETERY OR CREMATORIAL St Mary's Cemt		23d. LOCATION (City, town or county) Annapolis		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		ADDRESS Annapolis MD		25a. REC'D BY REGISTRAR DATE JUN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0354

CERTIFICATE OF DEATH

06339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 063 I 0 /		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
		1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland						
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis 8 hours					b. COUNTY Anne Arundel						
		c. LENGTH OF STAY IN 1b 8 hours					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater						
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS Rt-2, Box-130						
		3. NAME OF DECEASED (Type or print) Caroline					4. DATE OF DEATH June 15 1961						
		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED WIDOWED X		NEVER MARRIED Divorced		B. DATE OF BIRTH 3-19-1897			
		10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					11b. KIND OF BUSINESS OR INDUSTRY						
		11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.						
		13. FATHER'S NAME James Pratt					14. MOTHER'S MAIDEN NAME Mary Green						
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give rank or dates of service) No					16. SOCIAL SECURITY NO. 17. INFORMANT Address Otis Truman Edgewater Md.						
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Hemorrhage due to Hypertension (Arterial Disease)					INTERVAL BETWEEN ONSET AND DEATH 8 hrs.						
		Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. 331X											
		DUE TO (b) DUE TO (c)											
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)											
		20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		20c. TIME OF INJURY Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
		21. I certify that (I) Richardson attended the deceased from June 15, 1961 to June 15, 1961 , that (I) last saw the deceased alive on June 15, 1961 , and that death occurred at M , from the causes and on the date stated above.					21. I certify that (I) Richardson attended the deceased from June 15, 1961 to June 15, 1961 , that (I) last saw the deceased alive on June 15, 1961 , and that death occurred at M , from the causes and on the date stated above.					21. I certify that (I) Richardson attended the deceased from June 15, 1961 to June 15, 1961 , that (I) last saw the deceased alive on June 15, 1961 , and that death occurred at M , from the causes and on the date stated above.	
		22a. SIGNATURE R. L. Richardson					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 6/15/61	
		22c. PHYSICIAN'S NAME (Type) R. L. Richardson					22d. ADDRESS 110 Clay St., Annapolis, Md.						
		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-19-1961					23b. DATE THEREOF Chew's					23d. LOCATION (City, town or county) Westover Md.	
		24. FUNERAL DIRECTOR'S SIGNATURE William Reese Jr. Anna Md.					ADDRESS					25a. REC'D BY REGISTRAR DATE JUN 19 '61	
												25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

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Journal 2000

July 2000

Journal 2000

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1999-2000 - 2000

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2000-2001

July 2000 - August 2001

1999-2000

EDITION 7

Volume 1

2000

2000-2001

1999-2000

EDITION 6

July 2000

Volume 1

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death at age 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6355

CERTIFICATE OF DEATH

06340

1. PLACE OF DEATH e. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL ANNAPOLIS MARYLAND							
3. NAME OF DECEASED (Type or print) Lee		First Middle Roy		Last CONLEY		4. DATE OF DEATH Month Day Year June 2 1961	
5. SEX Male		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month Day Year Aug. 23 1961 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (County & State, or foreign country) Jackson North Carolina United States		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ute (N) CONLEY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) yes WWI - WWII		16. SOCIAL SECURITY NO. 220 30 0441		17. INFORMANT Wife SUSAN K. CONLEY		Address 30 Maryland Ave ANAPOLIS, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic heart disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)							
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 Dec., 1958 to 2 June, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 May 1961 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE S. Busch		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) S. BUSCH, LT MC USNR		22b. DATE SIGNED 3 JUNE 1961					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-6-61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery, Arlington, Va.		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Yarbro, Annapolis, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 7 '61		25b. REGISTRAR'S SIGNATURE Charles S. Tamm	

230

4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6356

CERTIFICATE OF DEATH

06341

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.			
M 10 I			
1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		b. COUNTY Baltimore City	
c. LENGTH OF STAY IN 1b 6 years 7mos. 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) Cornelia		4. DATE OF DEATH Last Month Day Year Cooper 6 28 19 61	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April, 1885?	
9. AGE (In years last birthday) 76? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stover James		14. MOTHER'S MAIDEN NAME Lula ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) Unknown		16. SOCIAL SECURITY NO. 17. INFORMANT Unknown Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hypostatic Pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Generalized & Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While ----- at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 11/26 1961 , to 6/28 1961 , that (I) (we) last saw the deceased alive on 6/28 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 6/29/61	
22e. SIGNATURE L. Benedict, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 30 Jun 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Univ. of Md.		23d. LOCATION (City, town or county) Balt.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II		25e. REC'D BY REGISTRAR DATE JUL 3 '61	
ADDRESS Cryptopsolis 108 W. Washington St		25b. REGISTRAR'S SIGNATURE S. Turek	

00841

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 13 & 14 Film G289 6/29/61 mh

06342

1. PLACE OF DEATH
e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

9 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Margaret

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

MARCH 18, 1910

8. DATE OF BIRTH

9. AGE (In years
last birthday)

51 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Months

11. BIRTHPLACE (County & State, or foreign country)

Days

12. CITIZEN OF WHAT COUNTRY?

Hours

13. FATHER'S NAME

Min.

Jacob M. Dicus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

331X

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

9 day

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerosis

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.Month, Day, Year
19
While
at work Not While
at work 20d. INJURY OCCURRED
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) attended the deceased from..... June 9, 1961, to..... June 18, 1961, that (I) last
saw the deceased alive on..... June 18, 1961, and that death occurred at..... M, from the causes and on the date stated above.

22e. SIGNATURE

Frank M. Shiple

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
6-19-61

121 Cathedral St., Annapolis, Md.

23e. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL

23b. DATE THEREOF

6-21-61

23c. NAME OF CEMETERY OR CREMATORIAL

Baldwin Memorial

23d. LOCATION (City, town or county)

Millersville, PA

(State)

Co. 19d.

24. FUNERAL DIRECTOR'S SIGNATURE

Hopping & Kirkley, Glen Burnie

25a. REC'D BY REGISTRAR

DATE JUN 23 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 VR A15 (4)
15M 9/60

SAE30

Johnson Smith

1965-1966

LORINIA SMITH

M

SAE30

1965-1966

LORINIA SMITH

SAE30
1965-1966

SAE30
1965-1966

SAE30

SAE30
1965-1966

SAE30
1965-1966

SAE30
1965-1966

SAE30
1965-1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06343

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 W. Fifth Ave.				d. STREET ADDRESS 5 W. Fifth Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alice Bohren Darby		First	Middle	Lost	4. DATE OF DEATH June 22,		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH May 11, 1891	Month 19 Year 61		
9. AGE (In years lost birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Albert Bohren		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Leslie W. Darby Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Left Ovarian Cancer (c) DUE TO		Cacccelia - Metastatic Carcinoma					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Jun 1961, to 22 June, 1961 , that (I) (we) last saw the deceased alive on 22 June 1961 , and that death occurred at 7 P.M. , from the causes and on the date stated above.			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on 22 June 1961 , and that death occurred at 7 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Andrew R. Sosnowski		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 23, 1961				
22c. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski		22d. ADDRESS 4016 Ritchie Hwy., Baltimore 25, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 26, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Pk.		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gence		ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE Conrad S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06344

6359

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5/6

I

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 18 years 8mos. 20 days		a. STATE Maryland b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					
3. NAME OF DECEASED (Type or print) Samuel		First	Middle	Last	4. DATE OF DEATH 6 14 1961
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		9. AGE (In years last birthday) 58 yrs.	
13. FATHER'S NAME Wesley Dashiell		14. MOTHER'S MAIDEN NAME Elizabeth ?		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Stomach Ulcer DUE TO (c) General Paresis INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----			
20c. TIME OF INJURY Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 9/24 , 19 42 A.M. 6/14 , 19 61 , that (I) (we) last saw the deceased alive on 6/14 , 19 61 , and that death occurred at 6:30 , from the causes and on the date stated above.					
22a. SIGNATURE Benedict		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6/17/1961		23c. NAME OF CEMETERY OR CREMATORIAL Fruitland	
24. FUNERAL DIRECTOR'S SIGNATURE Clickw. Stewart Salisbury 94d.		ADDRESS		23d. LOCATION (City, town or county) (State) Fruitland Md	
25a. REC'D BY REGISTRAR JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Pearce			

Item 18 Film 290 7-6-61
 Item 18 Film 291 7-27-61
 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06345

FOR STATE
HEALTH DEPT.



Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

delay is necessary,

File pages 1, 2, and 3 to the funeral director. Page

5 may be retained for your files.

File pages 1 and 2 with the State Board of Health.

within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First
RUBY

Middle
L.

Last
DePREMO

4. DATE
OF
DEATH
June 23 1961

Month
Day
Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

March 30, 1933

9. AGE (In years
last birthday)

28 2 yrs.

10. IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John L Gibson

14. MOTHER'S MAIDEN NAME

Mary C. Wootsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No no

16. SOCIAL SECURITY NO.

17. INFORMANT

Joseph DePremao - Husband - same as # 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

HYPOCAPNIA / ISOLATED / Cerebral edema

INTERVAL BETWEEN
ONSET AND DEATH

250X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) due to Colloid cyst of third ventricle, with obstruction of foramina of Monro

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/23/61

ACTUAL
SIGNATURE

W. Bradley King, Jr., M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Crematory)

22b. DATE THEREOF

June 26, 1961

22c. NAME OF CEMETERY OR CREMATORI

St. Mary's Cemetery

22d. LOCATION (City, town, or country)

Annapolis Maryland

(State)

23. FUNERAL DIRECTOR

Glen Hopping

Hopping Funeral Home

ADDRESS

Annapolis, Md.

24a. REC'D BY REGISTRAR JUN 28 61

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

DATE

RECEIVED THE STATE CHIEF OF POLICE
JAN 23 1940

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06346

FOR STATE
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY		Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Anne Arundel General Hospital				d. STREET ADDRESS		3 V O I - 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
EDWIN		A.	EASON	Dec. 18, 1898	June	22	19, 61						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Deys Hours Min.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 18, 1898		62 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Claims Dept.		Nationwide Ins.		North Dakota		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
George Eason		Lois # Watts		No		275-03-6734		Marian A. Eason-4413 Elderon Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Blunt-force head injury		DUE TO		INTERVAL BETWEEN ONSET AND DEATH					
819X		Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.				(b)							
		DUE TO				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Driver of auto in auto-auto/collision & fixed object.									
20c. TIME OF INJURY Month, Day, Year Hour XX p.m. 5:20 6/22 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
				Road		Arnold		Anne Arundel		Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>W. Bradley King, Jr., M.D.</i>											
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)		DATE SIGNED 6/23/61											
22a. BURIAL, CREMATION, REMOVAL		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		6/26/61		Woodlawn Cemetery		Woodlawn, Maryland							
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
<i>Ellsworth Armacost</i>		Ellsworth Armacost-4600 Liberty Hghts, Ave.		DATE JUN 26 '61		<i>Charles S. Kraus</i>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6362

CERTIFICATE OF DEATH

Reg. Dist. No.

06347

1. PLACE OF DEATH a. COUNTY A. A. County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 4, Box 106, Annapolis		c. LENGTH OF STAY IN 1b 10 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 4, Box 106, Annapolis,		d. STREET ADDRESS ---			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellis				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ellen Louise Ellis		First	Middle	Last	4. DATE OF DEATH June 25 1961	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1914	9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cheltenham, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles O. C. Rawlings		14. MOTHER'S MAIDEN NAME Pearl V. Colbert							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT J. Harold Ellis Route 4, Box 106, Annapolis		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown coronary thrombosis?		DUE TO 287X		INTERVAL BETWEEN ONSET AND DEATH sudden					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. generalized arteriosclerosis + hypertension		DUE TO (b)		5 years					
(c) obesity									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular accident in December 1960						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RT. 4, ANNAPOLIS, MD.		20f. (City or town) Cheltenham		(County) Md.	(State)
21. I certify that I attended the deceased from 11-21 , 19 61 , to 6-5 , 19 61 , that I last saw the deceased alive on 6-5 , 19 61 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Bertram C. R. Gau		ADDRESS (Street, city or town, state) RIVER-BAY-ROAD CAPE ST.-CLARE		DATE SIGNED 6/25/61					
PHYSICIAN'S NAME (Type) Bertram C. R. Gau, M. D.		22c. NAME OF CEMETERY OR CREMATORIAL Tayman Family Plot		22d. LOCATION (City, town, or county) Cheltenham		(State) Md.			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 6/27/61		22g. DATE OF DEATH 6-5-61					
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Brothers Fun'l Home		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JUN 29 '61		24b. REGISTRAR'S SIGNATURE Clifford L. Koenig			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31. COMMITTEE ON THE STATUS OF WOMEN IN THE STATE OF CALIFORNIA

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6363

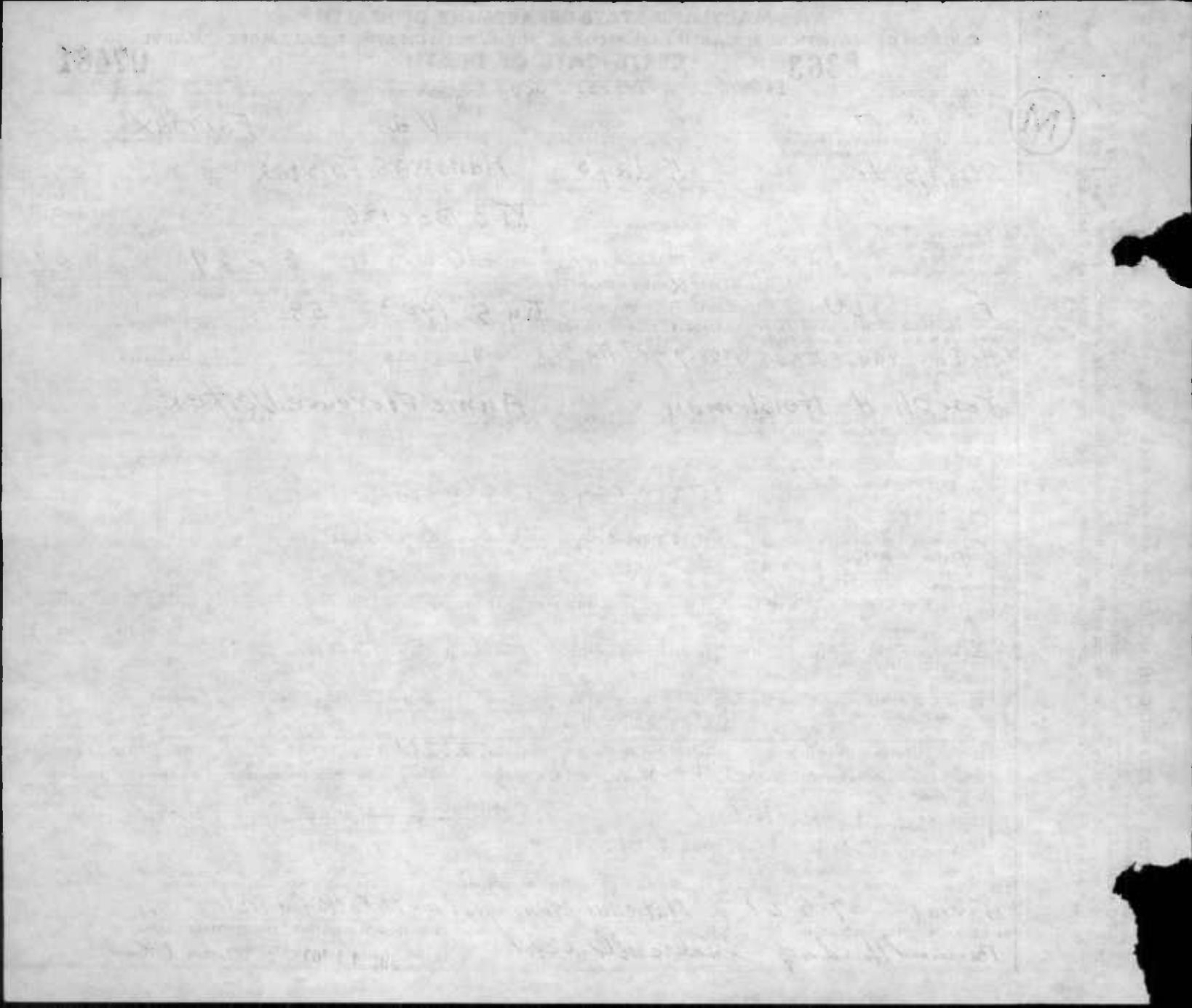
07481

CERTIFICATE OF DEATH

ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Items 11 & 12 Film 0290 7-3-61		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		e. STATE b. COUNTY	
Shady Side		5 days		Md-Nassau, Fairfax	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Lorena Heishman				Ellis	6 - 29 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
F		W		Jan 5 1903	58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Title Insurance Assoc. Mortgage Title Ins.				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Joseph H Heishman		Annie Florence Vetter		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes give war or dates of service)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } (b)		coronary artery disease			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from.....not at all....., to....., 19....., that (I) (we) last saw the deceased alive on.....not at all....., and that death occurred at.....M, from the causes and on the date stated above.		22b. DATE SIGNED			
22e. SIGNATURE Randy H. Wilson		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	coroner
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61		23c. NAME OF CEMETERY OR CREMATORIAL National Memorial / 16th & Falls Church Rd	
24 FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		ADDRESS Galena Lead		23d. LOCATION (City, town or county) (State) Va	
25e. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06348

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b	b. COUNTY A.H.C.O.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 CHESAPEAKE AVE		d. STREET ADDRESS 311 CHESAPEAKE AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PEARL M. EVANS	First	Middle	Last
4. DATE OF DEATH	Month 6	Day 10	Year 1961
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1883
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Melcher		14. MOTHER'S MAIDEN NAME GRACE NORWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT EARL EVANS		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Cold			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 12		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis (County) Md. (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. Lincoln Jr.		DATE SIGNED 6-10-61.	
EXAMINER'S NAME (Type) E. Lincoln Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/13/61	
22c. NAME OF CEMETERY OR CREMATORIAL HILLCREST		22d. LOCATION (City, town, or county) Annapolis (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR JUN 19 '61		DATE	
24b. REGISTRAR'S SIGNATURE Clifford S. Moore			

TO DEATHY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3881

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No. 06349

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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B					
ACTUAL SIGNATURE		WILLARD F. SMITH, MD		DATE SIGNED 6/18/61	
EXAMINER'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
30/06		6/20/61		ST. JAMES	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
T. A. Hockerty & Son, Galesville Md.				DATE JUN 26 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
MEDICAL CERTIFICATION					
1. PLACE OF DEATH a. COUNTY		Anne Arundel, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.Q.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Donald	Middle Eversfield	Last Lost	4. DATE OF DEATH Month June Day 17 Year 1961
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG 1, 1930	9. AGE (In years from birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) College Park, Md	
12. CITIZEN OF WHAT COUNTRY? U.S. A.					
13. FATHER'S NAME Octavius C. Eversfield		14. MOTHER'S MAIDEN NAME CATHERINE M. PETHERBRIDGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-30-1147		17. INFORMANT Peggy Anne Eversfield Fairhaven, Md	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fractured cervical spine		INTERVAL BETWEEN ONSET AND DEATH Immediate	
912.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Multiple fractured ribs, cerebral concussion, multiple contusions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor overturned and fell on patient			
20c. TIME OF INJURY Month, Day, Year Hour 6 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
June 17 1961				20f. (City or town) Fairhaven, A.Q., Md.	
(County)				(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
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NEGLIGENCE EXCLUDED FROM LIABILITY

1
FOR STATE
HEALTH DEPT.

M

4
TO FUNERAL DIRECTOR: Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06350

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum Heights		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #558 Forest View Road		d. STREET ADDRESS #558 Forest View Road	
3. NAME OF DECEASED (Type or print) KENNETH N. FAIR		4. DATE OF DEATH Last Month Day Year June 5th 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 18th April 1914
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Calvert Distillery	
11. BIRTHPLACE (State or foreign country) Schaller, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Fair		14. MOTHER'S MAIDEN NAME Nona Noll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) yes W.W. II		16. SOCIAL SECURITY NO. 17. INFORMANT 050 01 4698 Mrs. Minerva K. Fair Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1		INTERVAL BETWEEN ONSET AND DEATH sudden	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) { DUE TO DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5th June 1961	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10th June '61	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ida Grove Cemetery		22d. LOCATION (City, town, or country) (State) Ida Grove, Iowa	
23. FUNERAL DIRECTOR Richard V. Singleton		24a. REC'D BY REGISTRAR DATE JUN 7 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06351

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital		d. STREET ADDRESS 1920 Norman Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle CHARLES	Last FATH
4. DATE OF DEATH	Month JUNE	Day 21	Year 19 61
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4:45 AM
9. AGE (In years last birthday) yrs. 21		10. BIRTHPLACE (State or foreign country) Maryland	11. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
13. FATHER'S NAME Gordon A. Fath		14. MOTHER'S MAIDEN NAME Barbara Harmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Father: 1920 Norman Rd Glen Burnie, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Immaturity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the physician attended the deceased from birth 21 June 61 , 19, that (I) (we) last saw the deceased alive on 21 June 19 61 , and that death occurred at 7:20 P from the causes and on the date stated above.			
22a. SIGNATURE Roy M. Slezak		22b. DATE SIGNED 21 June 61	
22c. PHYSICIAN'S NAME (Type) ROY M. SLEZAK, Capt., M.C.		22d. ADDRESS USA Hosp Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23 61	
23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d. LOCATION (City, town, or county) Baltimore - Md	
24. FUNERAL DIRECTOR'S SIGNATURE Carl B. Woffington		ADDRESS General Store, 2nd & 63rd Sts, Belair Rd, Baltimore 6, Md	
25a. REC'D BY REGISTRAR DATE JUN 27 '61		25b. REGISTRAR'S SIGNATURE Clinton S. Thomas	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

6368

06352

1. PLACE OF DEATH
e. COUNTY

AFCO

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Leddy on Bay.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

80 N Anne Arundel St

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Charles H. Tarrar

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

MD

b. COUNTY

Prince Georges

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hedges Neck - Md 1604

d. STREET ADDRESS

7701 Revere Highway

a. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Feb. 1, 1900

9. AGE (In years
less, birthday)

61 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supervisor Doorman & P. Telephone Co. England

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Tarrar

14. MOTHER'S MAIDEN NAME

-

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address 7701 Revere Highway

INTERVAL BETWEEN
ONSET AND DEATH
No. 2 weeks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

434.4

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cardiac

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-10-61

ACTUAL
SIGNATURE

B. Gumprecht

E. L. Wherry

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial June 13-1961

22c. NAME OF CEMETERY OR CREMATORIUM

St. Lincoln Cemetery

22d. LOCATION (City, town, or country)

Prince George's Md

(State)

23. FUNERAL DIRECTOR

ADDRESS

J. Fletcher Wallace

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE JUN 13 '61

Arthur S. Thomas

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VS. A15ME
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06353

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 211 Wardour Drive	
3. NAME OF DECEASED (Type or print) Frank L. Foster		4. DATE OF DEATH Last Month Day Year June 29 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-1898	
9. 10e. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) PROFESSOR U.S.N.A PHYSICAL ED.		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK E. FOSTER		14. MOTHER'S MAIDEN NAME MURMIE E. KELLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO. W 4 I	
17. INFORMANT WILLIAM MORGAN #2		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 581.1		DUE TO Faneca Cirrhosus	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) multiple duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 3m	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part f or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work p.m. Not While at work 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-16-61 , to 6-29-61 , that (I) (we) last saw the deceased alive on 6-28-1961 , and that death occurred at 6:30 AM , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? NO	
22e. SIGNATURE Frank M. Blaylock		22b. DATE SIGNED 4-29-61	
22c. PHYSICIAN'S NAME (Type) FRANK M. BLAYLOCK		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Annapolis, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-3-61	
23c. NAME OF CEMETERY OR CREMATORIAL NAVAL ACADEMY		23d. LOCATION (City, town or county) Annapolis MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		25e. REC'D BY REGISTRAR DAJUN 30 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06354

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Sane		b. COUNTY Same							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Same		d. STREET ADDRESS Same							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marley Park				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Annie B. Green		First	Middle	Last	4. DATE OF DEATH 6/7/61	Month	Day	Year 19					
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?		9. AGE (in years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) A.A. County Md.		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Hall				14. MOTHER'S MAIDEN NAME Ellen Kess		Address CLIFTON							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charles Green (son) Pasadena, Md.		INTERVAL BETWEEN ONSET AND DEATH ?							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-hypertensive vascular diseases.													
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 <input type="checkbox"/> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 30 1961 to 6/7/61 (County) 6/7/61 (State)	
21. I certify that (I) (this hospital) attended the deceased from May 30 1961 to 6/7/61 , 19____, that (I) (we) last saw the deceased alive on 6/6/61 19____, and that death occurred at 7 AM , from the causes and on the date stated above.													
22a. SIGNATURE Gustave H. Faubert, M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/9/61			
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		22d. ADDRESS Glen Burnie, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/61		23c. NAME OF CEMETERY OR CREMATORIAL Mt Zion Church		23d. LOCATION (City, town, or county) Magothy - Md (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes		ADDRESS 638 N. Gilmore St. Baltimore MD		25a. REGD BY REGISTRAR Arthur S. Moore		25b. REGISTRAR'S SIGNATURE Arthur S. Moore							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6371

06355

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 65 Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Rose		First	Middle	Last	4. DATE OF DEATH GREENFIELD	Month	Dey	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1880	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Year Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Riga, Latvia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Files		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEMI DISEASE								
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) DIABETES MELLITUS; PERSISTENT CONGESTIVE FAILURE								
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.								
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 6-4 , 19 61 , to 6-17 , 19 61 , that (I) (we) last saw the deceased alive on 6-16 , 19 61 , and that death occurred at 10 AM , from the causes and on the date stated above.								
22e. SIGNATURE <i>Edward S. Beck</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.				22d. ADDRESS 73 Franklin Street, Annapolis, Md.				
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 18, 61		23c. NAME OF CEMETERY OR CREMATORIAL Kneseth Israel		23d. LOCATION (City, town or county) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hopping</i>		ADDRESS Hopping Funeral Home, Annapolis, Md.		25e. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>		

22690



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06356**

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?					
Rural - Box 216				X Rural - Box 216		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Edgewater		d. STREET ADDRESS		Edgewater		e. IS RESIDENCE ON A FARM?			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Female		Lizzie	Marshall	Harris	March 13-1881	June	13	1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years at birthday) 80 yrs.			
Female		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 13-1881		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Domestic			*****			A.A.Co., Md.			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Unknown					Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		None		William O. Harris- Edgewater, Md. Box 216							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac Disease</u>										<u>Sevler</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. L. Edwards</i>		EXAMINER'S NAME (Type) <i>E. L. Edwards</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>3/13/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-61		22c. NAME OF CEMETERY OR CREMATORIAL Brewer Hill		22d. LOCATION (City, town, or county) Annapolis, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6373

CERTIFICATE OF DEATH

06357

PLACE OF DEATH

e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

George

W.

Haughton

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Sept.

June 19, 89

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Brush
Door to Door

11. BIRTHPLACE (County & State, or foreign country)

Georgia

13. FATHER'S NAME

John Haughton

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

no

16. SOCIAL SECURITY NO.

212 30 1900

17. INFORMANT

Mrs. Josephine L. Haughton Wife same as # 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Aspirin
tremorINTERVAL BETWEEN
ONSET AND DEATH

24 hours.

177X DUE TO

Iles - paralytic

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first. } (b)

DUE TO

Prostate carcinoma

24 hours.

} (c)

6 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Paralysis by disease

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work 20d. INJURY OCCURRED
While at work
Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JAH to 6/27, 1967, that (I) (we) last saw the deceased alive on 6/27, 1967, and that death occurred at 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

G. Church

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Dr. Gerard Church 121 Cathedral St., Annapolis, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial June 30, 61

23b. DATE THEREOF

Cedar Bluff Cemetery

23d. LOCATION (City, town or county)

(State)

Annapolis, Md.

24 FUNERAL DIRECTOR'S SIGNATURE
Hepping Funeral Home

ADDRESS

Annapolis, Md.

25e. REC'D BY REGISTRAR

DATE JUN 30 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Indura emu

bivalva

Indura emu

stilogaster

stilogaster

acuta unicolor

Indura fringed lepto

emu

medullaria

spicula

em

88,000

8000

8000

I

stigaster

800,000

800,000

emula

no spicula

800,000

800,000

800

80,000,000 larvae

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6374

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06358

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY	MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
Anne Arundel County				a. STATE	b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton				Maryland	A. A. County				
c. LENGTH OF STAY IN lb few hours				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Whitmore Tavern, Route #175				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Wylie Hawthorn				June	15	1961			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/10/09	52 yrs.	Months	Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Engineer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
		Pollell, Texas			U.S.A.				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME								
I Jefferson Hawthorn	A. A. Johnson								
Address									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. II	16. SOCIAL SECURITY NO.	17. INFORMANT							
	578-07-4264	Mrs. Raymond Singleton Jr. (daughter)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease								
422.1	DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)								
	DUE TO								
	(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)		
Hour a.m. p.m.	19	While at work <input type="checkbox"/>	Not While at work <input type="checkbox"/>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Wiley Lovitt</i>									
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.									
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED June 16, 1961									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or country)		(State)				
Burial	19 June 61	Glen Haven Mem. Park	Glen Burnie		Maryland				
ADDRESS									
23. FUNERAL DIRECTOR <i>J. Kirkley</i>									
Hopping and Kirkley Funeral Home									
24a. REC'D BY REGISTRAR <i>JUN 20 '61</i> 24b. REGISTRAR'S SIGNATURE <i>John J. Kirkley</i>									
DATE									

82500

Group

Surfacing

Small Isabell Bay

Bottom

Small reef

Bottom

2000' depth

2000' depth, even bottom

100' depth

100' depth

20'

100' depth

100' depth

Bottom

Small Holes

Small bubbles

Bottom

Bottom

(bottom) at 2000' depth

Bottom

1
FOR STATE
HEALTH DEPT.

M

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06359

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN IB Over 5 years		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same		b. COUNTY Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Pleasant Beach		e. STREET ADDRESS Same		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Andrew E. Haynie		First A		Middle ndrew		Last E		4. DATE OF DEATH June 26th, 1961	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/99		9. AGE (In years last birthday) IF UNDER 1 YEAR 61 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Copper Koppers Co.		11. BIRTHPLACE (State or foreign country) Virginia.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andres Jackson Haynie		14. MOTHER'S MAIDEN NAME Elizabeth Jane Buchanan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9898		17. INFORMANT Mrs. Florence Haynie (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5020		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO		DUE TO		Pulmonary Emphysema		?	
{ cause last. (c)		DUE TO		DUE TO		Chronic Bronchitis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 6/27/61 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		Address (Street, city, town, or county) Glen Burnie, Md.							
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/61		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Mem. Pk.		22d. LOCATION (City, town, or country) (State) Glen Burnie, Md.			
23. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.		24e. REC'D BY REGISTRAR DATE JUN 28 '61		24b. REGISTRAR'S SIGNATURE Charles S. Krause			

20530

code date location entry no.

2052 Sept 5, 1967 San Joaquin Co., CA 10000

2053 San Joaquin Co., CA 10001

above is correct

10 below is correct

act initially no changes stra

named and typed by overall status, etc.

the original material and notes

revised and

name, etc., corrected

revision, etc.

20530

be held until material is ready

for the next day

and to be held until the next day

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6376

06360

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		MC		I		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1		MC		I		6376									
1		MC		I		06360									
1		MC		I		1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital									
1		MC		I		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis d. STREET ADDRESS 12 North Woodlawn Avenue									
1		MC		I		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4. DATE OF DEATH June 30 1961 Last Month Dey Year Hendricks									
1		MC		I		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
1		MC		I		8. DATE OF BIRTH June 29, 1961 9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min.									
1		MC		I		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby Boy 10b. KIND OF BUSINESS OR INDUSTRY									
1		MC		I		11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Annapolis, Md. USA									
1		MC		I		13. FATHER'S NAME Marshall E. Hendricks 14. MOTHER'S MAIDEN NAME Margaret Mutchler Address									
1		MC		I		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes, give rank and date of service)									
1		MC		I		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) } DUE TO (c) <i>Prematurity</i>									
1		MC		I		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
1		MC		I		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
1		MC		I		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20f. (City or town) (County) (State) p.m. 19									
1		MC		I		21. I certify that (I) (this hospital) attended the deceased from 6-29, 1961 to 6-30, 1961, that (I) (we) last saw the deceased alive on 6-30, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.									
1		MC		I		22a. SIGNATURE <i>Clayton Norton</i> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dr. Clayton Norton									
1		MC		I		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Severna Park, Md.									
1		MC		I		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State) Burial July 1, 61 Hellcroft Cemetery Annapolis, Md.									
1		MC		I		24. FUNERAL DIRECTOR'S SIGNATURE <i>Hopkins F. Walker</i> ADDRESS 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS Home Annapolis. DATE JUL 5 '61 Arthur S. Kraus									

98230

3702

Leburia eximia

Leburia eximia

Leburia eximia

(M)

alligata

alligata

(L)

several individuals of size 25

several individuals of size 25

OK - eximia

eximia

eximia

several species

several species

Brook Litter

abundant

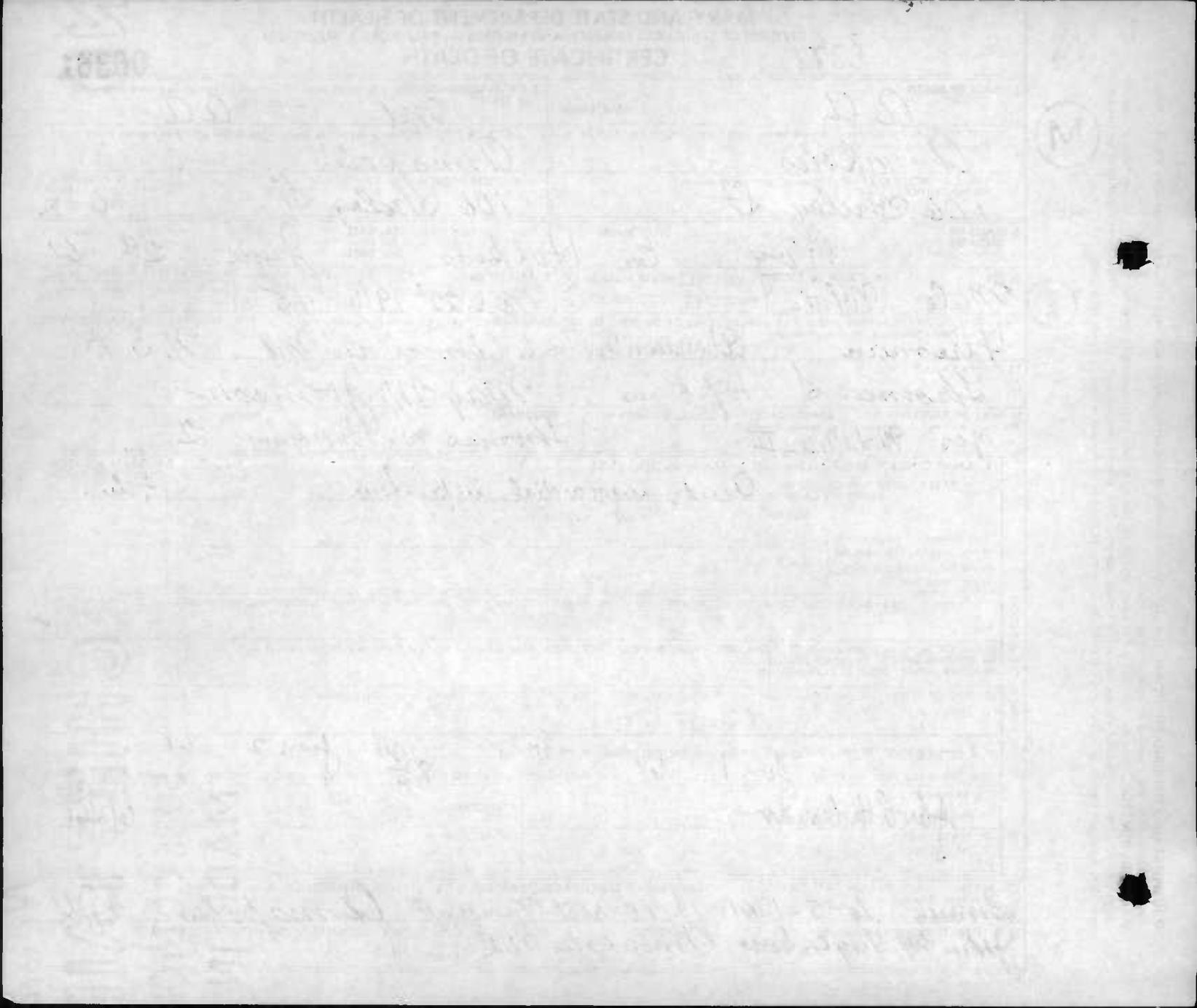
abundant

abundant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>a.a.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>a.a.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>106 Shirley St</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>106 Shirley St</i>				d. STREET ADDRESS <i>106 Shirley St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Poy</i>		First	Middle	4. DATE OF DEATH <i>E. Hopkins</i>		Month	Day	Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 22^d 1916</i>		9. AGE (In years last birthday) <i>45 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Aberdeen Pro. Co.</i>				11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>			
12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>											
13. FATHER'S NAME <i>Thomas S. Hopkins</i>				14. MOTHER'S MAIDEN NAME <i>May M. Johnson</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> <small>If yes, give war or dates of service)</small> <i>World War II</i>				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Thomas S. Hopkins 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>from</i>							
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Annapolis</i>		(County) <i>Annanoplis</i>		(State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1 1961</i> to <i>June 2 1961</i> , that (I) (we) last saw the deceased alive on <i>June 1 1961</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Adolph H. Klemmer</i>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>6/3/61</i>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-5-1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Memorial</i>		23d. LOCATION (City, town, or county) <i>Annapolis</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis MD</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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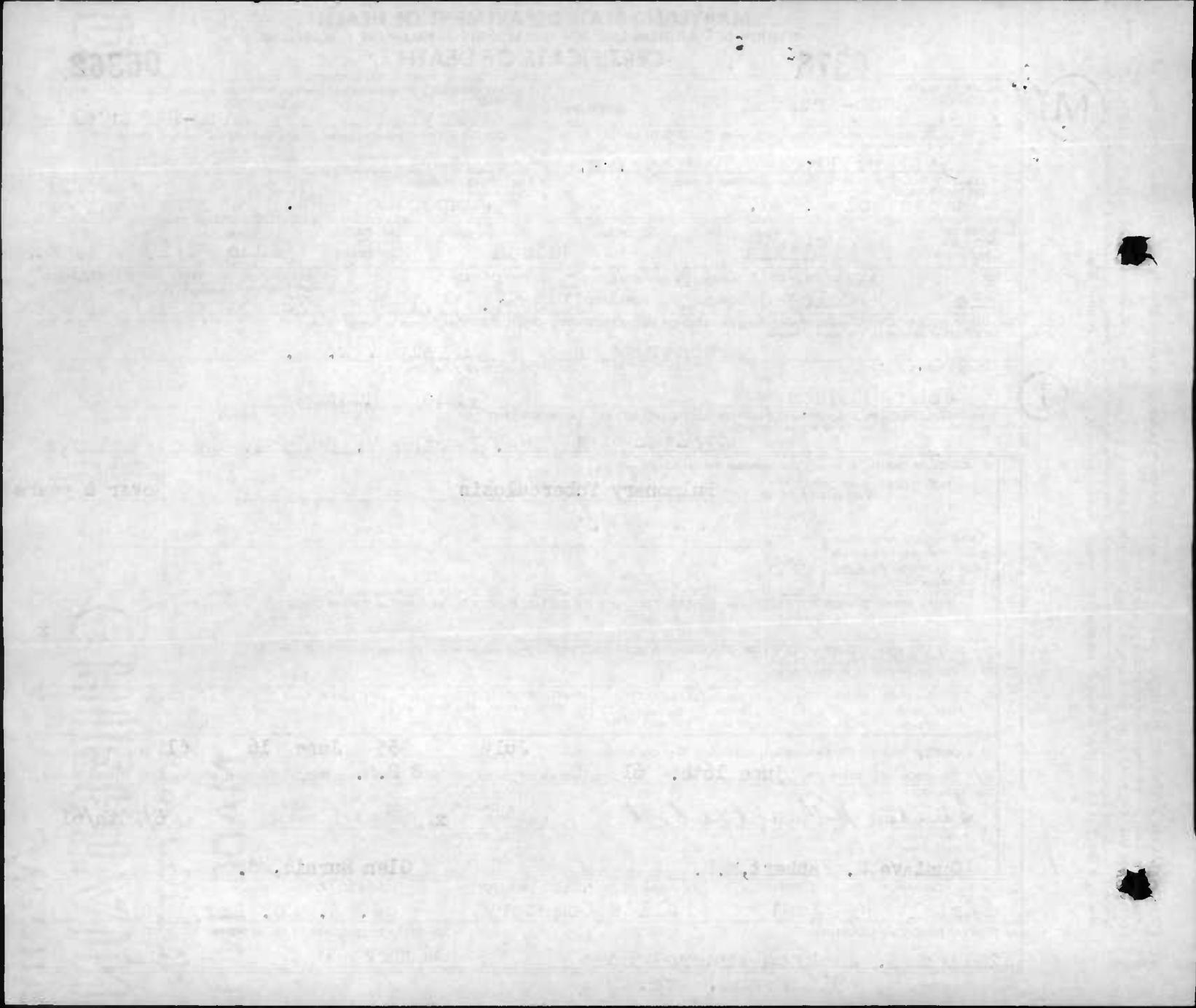
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06362

6378

1. PLACE OF DEATH a. COUNTY Anne-Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne-Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millerville	c. LENGTH OF STAY IN 1b 65 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jumper Hole, Rd.	d. STREET ADDRESS Jumper Hole Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Millikin	First	Middle Hudson	4. DATE OF DEATH Month June Day 17 Year 1961
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farmer	9. AGE (In years last birthday) yrs. 72
		11. BIRTHPLACE (State or foreign country) Enfield, N. C.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Hudson		14. MOTHER'S MAIDEN NAME Jane Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 218-14-8702	17. INFORMANT Mrs. Bertha V. Hudson, Same as Above Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH over 6 years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO		Pulmonary Tuberculosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1955, to June 16, 1961, that (I) (we) last saw the deceased alive on June 16th, 1961 and that death occurred at 8 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 6/20th/61	
22a. SIGNATURE Gustave H. Faubert, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/20th/61
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		22d. ADDRESS Glen Burnie, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/61	23c. NAME OF CEMETERY OR CREMATORIAL Hall's Cemetery
23d. LOCATION (City, town, or county) A. A. Co. Maryland (State)		23e. REC'D BY REGISTRAR DATE JUN 21 '61	
24. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson Funeral Home		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS 916 Penna. Ave. # 1			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06363

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Last Month Day Year June 28 1961	
5. SEX Male White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 27, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert N. Humphreys		14. MOTHER'S MAIDEN NAME Katherine Delores McCoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO <i>prematurity</i> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore	(County) Md.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from June 27, 1961 to June 28, 1961, that (I) (we) last saw the deceased alive on June 28, 1961, and that death occurred at <i>home</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Neil Sims</i>		22b. DATE SIGNED JUL 3 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Neil Sims		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Cathedral St. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 30, 61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill	23d. LOCATION (City, town or county) (State) Baltimore 25, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		25e. REC'D BY REGISTRAR DATE JUL 3 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

M

Lobularia maritima

Foeniculum vulgare

Alstroemeria

Microseris

Isocoma menziesii

Rudbeckia laciniata L. subsp. laciniata

Scirpus americanus

Athyrium filix-femina

Lomatium nudicaule

Calochortus

Yucca whipplei

Thlaspi arvense

Calochortus

Yucca whipplei

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6380

CERTIFICATE OF DEATH

Reg. Dist. No.

06364

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		c. LENGTH OF STAY IN lb 38 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		d. STREET ADDRESS Rt. #175 - N/A Dairy Farm	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #175 N/A Dairy Farm				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle A.	Last HUTCHINS, Sr.	4. DATE OF DEATH 2nd, Aug. '03	Month June	Day 10	Year 19 61
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2nd, Aug. '03	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY N/A Dairy Farm		11. BIRTHPLACE (State or foreign country) Eastport, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis D. Hutchins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220 16 5220		17. INFORMANT Mrs. Catherine W. Hutchins,		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Sclerotic Cardiovascular Disease DUE TO (c) —							
INTERVAL BETWEEN ONSET AND DEATH half hour							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Port Republic	(County) Talbot Co.	(State) Md.
21. I certify that I attended the deceased from June 10, 1961 , to June 19, 1961 , that I last saw the deceased alive on June 10, 1961 , and that death occurred at 5:45 p.m. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Felicia Freeland		ADDRESS (Street, city or town, state) 609 00 Eutaw Rd - 611261					
PHYSICIAN'S NAME (Type) Richard V. Singleton		DATE SIGNED 6/12/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13th June '61	22c. NAME OF CEMETERY OR CREMATORIAL Baldwin Mem. Ch. Cem.		22d. LOCATION (City, town, or county) Millersville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton		ADDRESS Glen Burnie, Md.	24a. REC'D BY REGISTRAR JUN 15 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Tracy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

STATE OF PENNSYLVANIA
CEREMONIALS OF DEATH

DEATH CERTIFICATE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6381

CERTIFICATE OF DEATH

06365

1. PLACE OF DEATH e. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		b. COUNTY Talbot	
c. LENGTH OF STAY IN 1b 3 years 3 mos. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 323 Port Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Tilghman		First Elmer	Middle Jenkins
4. DATE OF DEATH 6 20 1961	Month 6	Day 20	Year 19 61
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 3, 1896
9. AGE (In years less birthday) 64 yrs.	IF UNDER 1 YEAR Months 64	IF UNDER 24 HRS. Hours 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Worker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Jenkins		14. MOTHER'S MAIDEN NAME Christinia Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT 1918-1919 130-01-8285 Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
591X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO Nephrosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----	
20c. TIME OF INJURY Month, Day, Year Hour ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/19 1958, to 6/20 19 61, that (I) (we) last saw the deceased alive on 6/20 19 61, and that death occurred at 2:33, from the causes and on the date stated above.		22b. DATE SIGNED 6/20/61	
22e. SIGNATURE <i>John Benedict</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/61	
23c. NAME OF CEMETERY OR CREMATORIAL Richard Com.		23d. LOCATION (City, town or county) (State) Easton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dahlill</i>		ADDRESS Easton Md.	
25e. REC'D BY REGISTRAR DATE JUN 23 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6382

CERTIFICATE OF DEATH

Reg. Dist. No.

06366

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital		d. STREET ADDRESS 2331 Lorretta Ave	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	-	-	JOHNSON	JUNE	1	19	61

5. SEX Female	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> - DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3:20 AM 1 June 61	9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
								50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	--

13. FATHER'S NAME William Louis Johnson	14. MOTHER'S MAIDEN NAME Hattie Creech
---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	16. SOCIAL SECURITY NO. -	17. INFORMANT Mother 2331 Lorretta Ave Balto, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) DUE TO (c) DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
---	---	--	---------------------	----------	---------

21. I certify that I attended the deceased from 3:20 AM 1 June 61 , to 8:10 AM 1 June 61 , that I last saw the deceased alive on 1 June 19 61 , and that death occurred at 8:10 AM , from the causes and on the date stated above.					
--	--	--	--	--	--

ACTUAL SIGNATURE <i>Sherman S. Robinson</i>	M.D.	ADDRESS (Street, city or town, state) USA Hosp Ft Geo G Meade, Md.	DATE SIGNED 1 June 61
--	------	--	---------------------------------

PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, Capt., M.C.
--

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7 June 61	22c. NAME OF CEMETERY OR CREMATORIAL LABORATORY USA Hosp LABORATORY	22d. LOCATION (City, town, or county) Ft. Geo. G. Meade Md
---	---------------------------------------	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>Shirley J. Linden</i>	ADDRESS Ft. Geo. G. Meade Md	24a. REC'D BY REGISTRAR DATE JUN 9 '61	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>
--	--	---	---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

STATE OF CALIFORNIA - SAN FRANCISCO COUNTY

CERTIFICATE OF DEATH

Deceased's Name	Age	Date of Birth	Date of Death	Place of Death
John Doe	55	1900-01-01	1955-05-15	Hospital
Cause of Death				
Heart Disease				
Residence at time of death				
123 Main Street, San Francisco, CA				
Name and address of physician				
Dr. John Smith, 456 Market Street, San Francisco, CA				
Name and address of funeral director				
ABC Funeral Home, 789 Market Street, San Francisco, CA				
Signature of physician or coroner				
John Doe, M.D.				
Signature of certifying officer				
John Doe, M.D.				
Date of certificate				
1955-05-15				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6383

CERTIFICATE OF DEATH

Reg. Dist. No.

06367

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 4th Ave. S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Katherine	Last Kearney
4. DATE OF DEATH	Month June	Day 10	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1915
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William J. Kelly		14. MOTHER'S MAIDEN NAME Anna Marie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Edward Kearney
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma Breast (c) DUE TO 8 Months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 61 , to June , 19 61 , that I last saw the deceased alive on June 10 , 19 61 , and that death occurred at 6:00P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 202 Crain Hwy S.W.	
ACTUAL SIGNATURE C. R. MacDonald M.D.		DATE SIGNED June 11/61	
PHYSICIAN'S NAME (Type) C. R. MacDonald M.D.		Glen Burnie Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery
22d. LOCATION (City, town, or county) Glen Burnie, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		24a. REC'D BY REGISTRAR JUN 15 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas
ADDRESS Glen Burnie, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

SI BROWNS—HISASH TO THE VARIOUS STATE CHAIRMEN

HEADS TO STAFFED

237

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06368

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

Annapolis

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

S.O.H. Anne Arundel General

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Marguerite

Lindauer

4. DATE
OF
DEATH

Month

Dey

Year

Apt. 709 3W

47X3

6

24

19 61

5. SEX

F

6. COLOR OF FACE

u

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

4. 23 - 09

9. AGE (In years
last birthday)

52 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Prof. Social Worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Oregon

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis P. Mauzy

14. MOTHER'S MAIDEN NAME

Etta Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or service)

no

16. SOCIAL SECURITY NO. 17. INFORMANT

579-48-8825 Frederick J. Lindauer same 2-d

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4344

Cancer

INTERVAL BETWEEN
ONSET AND DEATH

Scattered

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Dey, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

6/24/61

ACTUAL
SIGNATURE

E. Lindauer

E. Lindauer

EXAMINER'S
NAME (Type)

Princess Georges Co.

Md.

Burial

6/27/61

Cedar Hill Cemetery

ADDRESS

The S. H. Hines Company Washington, D.C.

DATE 27 '61

Death & Taxes

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATUM 27 '61

Death & Taxes

23. FUNERAL DIRECTOR

ADDRESS

The S. H. Hines Company Washington, D.C.

DATE 27 '61

Death & Taxes

24. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATUM 27 '61

Death & Taxes

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06369

1. PLACE OF DEATH e. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residencia before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Anne Arundel	
Annapolis		10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					
Anne Arundel General Hospital					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Perry			McGOWAN	June 21	19 61
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	January 8, 1879	82 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
LABORER			11. BIRTHPLACE (County & State, or foreign country)		
13. FATHER'S NAME			Maryland		
ROBERT McGOWAN			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)			U.S.		
16. SOCIAL SECURITY NO.			17. INFORMANT Address		
218-143481					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: Cerebral Vascular Accident					
IMMEDIATE CAUSE (a) DUE TO					
Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease					
} (c) Generalized arteriosclerosis					
} DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year	Hour a.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
	p.m.	19			
21. I certify that (I) attended the deceased from June 14, 1954 to June 21, 1961, that (I) last saw the deceased alive on June 21, 1961, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE					
Theodore H. Johnson, M.D. M.D.					
22b. DATE SIGNED					
June 23, 1961					
22c. PHYSICIAN'S NAME (Type) Theodore H. Johnson, M. D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY					
Burial 6-25-61 Brewer Bell East Annapolis, Md					
23d. LOCATION (City, town or county) (State)					
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
James H. Johnson, Annapolis, Md					
25a. REC'D BY REGISTRAR JUN 28 '61 25b. REGISTRAR'S SIGNATURE					
Arthur S. Kraus					

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06370

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

P.O. Severna Park

c. LENGTH OF STAY IN lb

7 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Earleigh Heights

3. NAME OF
DECEASED
(Type or print)

First

Middle

Clifford Heath Mc Neil

5. SEX

6. COLOR OR RACE

M

C

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

7/5/93

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Real Estate

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Panama

13. FATHER'S NAME

Charles McNeil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

117-03-0235

17. INFORMANT

Ada Sophia Heath

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e.)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

420/1
Conditions, if any, which
gave rise to immediate cause
(e.), stating the underlying
cause last. } (b)

DUE TO

cause last. } (c)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/16/61

Glen Burnie, Md.

ACTUAL
SIGNATURE

Gustave H. Faubert, M.D.

EXAMINER'S
NAME (Type)

22e. BURIAL, CREMATION
REMOVAL (Specify)

22f. DATE THEREOF

22g. NAME OF CEMETERY OR CREMATORY

22h. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

24f. REGISTRAR'S SIGNATURE

William Beest Anna M.D.

DATE JUN 19 '61

Arthur S. Kraus

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 18 Film 288 6-16-61 ams				06371									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 8 hours c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Annapolis									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-3, Box-419									
3. NAME OF DECEASED (Type or print) (Twin B)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
4. DATE OF DEATH Last Middle				Month Day Year									
5. SEX Male White 6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH MEIKLEJOHN June 4, 1961									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY									
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME William Donald Meiklejohn				14. MOTHER'S MAIDEN NAME Jessie May Ward									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Cardiac & Respiratory failure INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Immaturity													
DUE TO (c) Premature labor													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a); 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (checkmark) attended the deceased from June 4, 1961, to June 5, 1961, that (I) (X) last saw the deceased alive on June 5, 1961, and that death occurred at 3:00 A.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>W.P. Stephens</i>				M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 6/6/61	
22c. PHYSICIAN'S NAME (Type) William P. Stephens				22d. ADDRESS 38 Cornhill St., Annapolis, Md.									
23a. BURIAL REMOVAL (Specify) REMOVAL				23b. DATE THEREOF 6/6/61				23c. NAME OF CEMETERY OR CREMATORIAL V. O'Brien, Med. School				23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>W.P. Stephens</i>				ADDRESS									
								25a. REC'D BY REGISTRAR DATE JUN 8 '61				25b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

51830

1960-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6388

CERTIFICATE OF DEATH

06372

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First David	Middle 	Last MYERS				
4. DATE OF DEATH June 13 1961	Month June	Day 13	Year 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1909				
9. AGE (In years last birthday) 51 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop.	11. KIND OF BUSINESS OR INDUSTRY Tavern	12. BIRTHPLACE (County & State, or foreign country) Maryland				
13. CITIZEN OF WHAT COUNTRY? U.S.	14. FATHER'S NAME David V. Myers	15. MOTHER'S MAIDEN NAME Grace Meeks	16. SOCIAL SECURITY NO. 219 03 5209				
17. INFORMANT Mrs. Helen B. Myers, Wife - same as #2	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331X (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20. INTERVAL BETWEEN ONSET AND DEATH 28 hrs.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	21. I certify that (I) Frank M. Shipley attended the deceased from 6.12 , 1961, to June 13, 1961 , that (I) Frank M. Shipley last saw the deceased alive on June 13, 1961 , and that death occurred at M. from the causes and on the date stated above.	22. SIGNATURE Frank M. Shipley				
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley	20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 	
21. I certify that (I) Frank M. Shipley attended the deceased from 6.12 , 1961, to June 13, 1961 , that (I) Frank M. Shipley last saw the deceased alive on June 13, 1961 , and that death occurred at M. from the causes and on the date stated above.	22. DATE SIGNED 11:55 A.M.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 121 Cathedral St., Annapolis, Md.	23d. LOCATION (City, town or county) Annapolis, Md.	(State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 16, 61	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial Cemetery	23d. LOCATION (City, town or county) Annapolis, Md.	(State) 			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home	ADDRESS Annapolis, Maryland	25e. REC'D BY REGISTRAR JUN 16 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hopping				
VR A15 (4) 15M 9/60							

1

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06373

Reg. Dist. No.

6389

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>A. C. O.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikeville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. Anne Arundel General</i>		d. STREET ADDRESS <i>710 Silver Creek Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Melvin R. Meyers</i>		First <i>Melvin</i>	Middle <i>R</i>
Last <i>Meyers.</i>		Last <i>Meyers.</i>	4. DATE OF DEATH Month <i>6</i> Month <i>30</i> Year <i>1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-7-1931</i>
9. AGE (In years last birthday) <i>30 yrs.</i>		10. IF UNDER 1 YEAR Months <i>30</i>	11. IF UNDER 24 HRS. Days <i>0</i> Hours <i>0</i> Min. <i>00:00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Firefighter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. City Fire Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Raymond N. Myers</i>		14. MOTHER'S MAIDEN NAME <i>Elsie L. Eaton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr. Joan E. Myers 4553 Reisterstown Rd.</i>	
17. INFORMANT <i>Mrs. Joan E. Myers</i>		Address <i>4553 Reisterstown Rd., Baltimore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Glaucoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Boat kernel gun -</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Boat kernel gun -</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>C - 30 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Not while at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Chestnut Hill</i>
20f. (City or town) <i>A. C. O.</i>		(County) (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED <i>6-30-61</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-3-61</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Dyers</i>		ADDRESS <i>8728 Liberty Rd. Randallstown, Md.</i>	
24a. REC'D BY REGISTRAR <i>Curtis S. Trahan</i>		24b. REGISTRAR'S SIGNATURE <i>Curtis S. Trahan</i>	

WATERMARK DESIGN BY THE FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

31
FOR STATE
HEALTH DEPT.



TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06374

1. PLACE OF DEATH

e. COUNTY

Anne Arundel County

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Severn

c. LENGTH OF STAY IN lb

All life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Ft. Meade Rd., Box 179-B

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Ezekiel

4. DATE
OF
DEATH

June 15,

1961

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED

 NEVER MARRIED

WIDOWED

 DIVORCED

8. DATE OF BIRTH

7/4/91

9. AGE (in years
last birthday)69⁷⁰ yrs.

IF UNDER 1 YEAR

Months Dey

IF UNDER 24 HRS.

Hours Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

A.A.Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Israel Oliver

14. MOTHER'S MAIDEN NAME

Armiger Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

Yes

W.W. I

16. SOCIAL SECURITY NO.

17. INFORMANT

Dennis Oliver, (Nephew)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

420.1
Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATURE
*Ezekiel E. Standard*CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/15/61

EXAMINER'S
NAME (Type)

G. H. Faubert, M. D.

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-19-61

22c. NAME OF CEMETERY OR CREMATORI

Baltimore, National

22d. LOCATION (City, town, or country)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR

ADDRESS

William A. Jackson Funeral Home Inc.
916 Pennsylvania Ave. Balt. 1, Md.

24a. REC'D BY REGISTRAR

DATE JUN 21 '61

24b. REGISTRAR'S SIGNATURE

*Arthur L. Krause*VS. A15ME
5M 7/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6391

06375

1. PLACE OF DEATH e. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN lb Hrs; 5		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 26 Clay St.,	
3. NAME OF DECEASED (Type or print) William Clifton		4. DATE OF DEATH Last Month Day Year PARKER June 12 19 61	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1908	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) 53 yrs.	
DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Keeper	
11. KIND OF BUSINESS OR INDUSTRY [Signature]		12. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME James Parker, Sr		14. MOTHER'S MAIDEN NAME Katie Mc Gowan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No (If yes give rank or date of service)		16. SOCIAL SECURITY NO. 219-16-2235	
17. INFORMANT Marie Pointer		Address 100 W. Washington St Annapo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO Hyperthyroid Vasculitis Disease Grade IV INTERVAL BETWEEN ONSET AND DEATH 1 dy		IMMEDIATE CAUSE (a) 33 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from..... June 12, 1961, and that death occurred at.....M, from the causes and on the date stated above.		22a. SIGNATURE Theodore H. Johnson	
21b. PHYSICIAN'S NAME (Type) Theodore H. Johnson		22b. DATE SIGNED 2:23 P.M. 6/13/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-61	
23c. NAME OF CEMETERY OR CREMATORIAL PineLawn		23d. LOCATION (City, town or county) Annapolis Md	
24 FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks, III		ADDRESS Annapolis, Md	
		25e. REC'D BY REGISTRAR DATE JUN 16 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

65228

477

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6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06376

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 (at the top) to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6392			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va. b. COUNTY Wood	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mago Vista, Pasadena few minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mago Vista Beach		d. STREET ADDRESS 1404 Crescent St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Paul	Middle Edward	Last Patterson
4. DATE OF DEATH	Month June	Day 20	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1935
9. AGE (In years less birthday) 26 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Amusement Operator	11. BIRTHPLACE (State or foreign country) Parkersburg, W. Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Aubra L. Patterson	14. MOTHER'S MAIDEN NAME Josie M. Taylor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 232-52-4456	17. INFORMANT Mr. A. L. Patterson, same as 2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929 • 8 DUE TO Accidental Drowning Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went swimming in the Magothy River and suddenly drowned	
20c. TIME OF INJURY Hour 8.30 a. m. p. m.	Month, Day, Year 6/20/61 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Magothy River
			20f. (City or town) Magovista Beach (County) A.A. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/23/61
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Glen Burnie, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6/23/61	22c. NAME OF CEMETERY OR CREMATORIAL Wilding	22d. LOCATION (City, town, or county) Jackson Co. W. Va. (State)
23. FUNERAL-DIRECTOR'S SIGNATURE <i>William J. Licenius</i>	ADDRESS Baltimore, Md.	24a. REC'D BY REGISTRAR DATE JUN 26 '61	24b. REGISTRAR'S SIGNATURE <i>John S. Thorne</i>

MECHANICAL EXAMINERS CERTIFIED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 & 2 Film G290 7/3/61 iwk

Reg. Dist. No. 06377

6393

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Anne Arundel <i>A.A. FREE TOWN</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freetown, Glenburnie		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X GLEN BURNIE - Freetown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 323 RT 1</i>		d. STREET ADDRESS <i>Box 323 RT 1</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Asbury Pearson		First	Middle
		Lost	4. DATE OF DEATH Month 6 Day 25 Year 1961
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 25, 1883</i>
9. AGE (In years lost birthday) <i>77 yrs.</i>		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clergyman</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>MARYLAND</i>			
13. FATHER'S NAME William Pearson		14. MOTHER'S MAIDEN NAME SARAH TAYLOR HAYES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>LILLIE PEARSON (WIFE) (SAME)</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i> DUE TO <i>Arteriosclerotic Cardio-vascular disease</i> 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic, generalized, hypertrophic osteoarthritis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Chronic, generalized, hypertrophic osteoarthritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>January 3, 1950, to June 25, 1961.</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 3, 1950, to June 25, 1961.</i> that I last saw the deceased alive on <i>June 24, 1961</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>308 Mountain Rd. Pasadena, Md. 21122</i>	
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		DATE SIGNED <i>July 29, 1961</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVED (Specify) <i>Burial 6/28/61</i>		22b. DATE THEREOF <i>6/28/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Hall Memorial Cemetery</i>
22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		22e. ADDRESS <i>108 E. 20th St. Montgomery, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sarah B. Brown & Son, Montgomery, Md.</i>		24a. REC'D BY REGISTRAR <i>JUN 29 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kuhn</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BUREAU OF

CERTIFICATE OF DEATH

Date of Birth _____

Cause of Death _____
Date of Death _____

Signature _____

Name
of
DeceasedName
of
PhysicianName
of
Hospital

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

Disease or Injury
 Accidental
 Natural
 Suicide
 Homicide
 Stillborn
 Other _____

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6394

06378

1. PLACE OF DEATH a. COUNTY		Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Annapolis		c. LENGTH OF STAY IN lb		a. STATE Maryland							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Anne Arundel General Hospital		3 days		b. COUNTY Anne Arundel							
e. NAME OF DECEASED (Type or print)		First	Middle	Last	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
Osma		M.		PENNINGTON	X RURAL - Annapolis								
f. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	d. STREET ADDRESS		d. DATE OF DEATH		Month	Day	Year		
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Rt-2		January 29, 1902		59	11	19 61		
g. AGE (in years last birthday)				e. DATE OF BIRTH		9. IF UNDER 1 YEAR		IF UNDER 24 HRS.					
59 yrs.				January 29, 1902		Months		Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Farmer		Farmer		West Virginia		U.S.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
Adelbert Pennington		Willie Bird		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		aspiration pneumonia		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Penitontitis		aspiration pneumonia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Intestinal obstruction (volvulus)		Penitontitis		3 hours							
DUE TO cause last. (c)		4 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		June 8, 1961		Month, Day, Year		White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		June 8, 1961		(City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from..... June 8, 1961, to..... June 11, 1961, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on..... June 11, 1961, and that death occurred at..... M, from the causes and on the date stated above		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS		22e. DATE SIGNED							
22a. SIGNATURE		Richard I. Hochman M.D.		100 Cathedral St., Annapolis, Md.		6/13/61							
22c. PHYSICIAN'S NAME (Type)		Richard I. Hochman		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)	
Burial		June 14-1961		Asbury Cemetery		Arnold		Md					
24. FUNERAL DIRECTOR'S SIGNATURE		John W. Taylor Sons Annapolis Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John W. Taylor Sons Annapolis Md.				DATE JUN 19 '61		Clyde S. Thorne							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

6395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06379

1. PLACE OF DEATH

Anne Arundel

MARYLAND

a. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Laurel

c. LENGTH OF STAY IN 1b

10 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route I - Box 167

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

M.

W.

WIDOWED

DIVORCED

4. DATE
OF
DEATHJUNE-29th

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

5/29/10

5/29/10

5/29/10

9. AGE (in years
last birthday)

51 yrs.

Months

Days

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Hours Min.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

SET-UP-MAN-AT-MOULDING-CORP. Anderson, Indiana U.S.A.

13. FATHER'S NAME Harry Perkinson

14. MOTHER'S MAIDEN NAME Margaret Mayda (Merle)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

201-34-0007 - Mrs. Irene Wella Perkinson (wife)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY - OCCLUSION.

INTERVAL BETWEEN
ONSET AND DEATH
survived.

4 20.1 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

21. WAS AUTOPSY PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 20d. INJURY OCCURRED While at work Not While at work

p.m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opiniondeath resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE Gustav E. H. FAUBERT, M.D.

EXAMINER'S NAME (Type) Gustav E. H. FAUBERT, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM

Burial July 3, 1961 Indianapolis Nat'l Cemetery

22d. LOCATION (City, town, or county) (State)

Glen Burnie Md.

23. FUNERAL DIRECTOR ADDRESS

DeWitt McDonald, Laurel, Md.

RECD BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

21500



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. If death occurs at home or in a hospital, the physician may fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(C)
M
I

06380

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN lb

7 hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL - Severn

d. STREET ADDRESS

Donald Ave.,

Last

4. DATE
OF
DEATH

Month

Day

Year

PIERCE

June

10

1961

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

June 10, 1961

9. AGE (In years
last birthday)

yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

6

45

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

U.S.

13. FATHER'S NAME

Joseph Albert Pierce

14. MOTHER'S MAIDEN NAME

Yvonne Celeste Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

776X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

6 hrs.

Pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (X) attended the deceased from June 10, 1961, to June 10, 1961, that (I) (X) last saw the deceased alive on June 10, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Stuart M. Walker

10:45 A.M.

22b. DATE
SIGNED

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR Crematory

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JUN 19 '61

Carlyle S. Thomas

RECEIVED

BEST COPY

YANNIS VASSILIS

10 OF 000

EX-100

10 OF 1000

EX-100

10 OF 1000

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10 OF 000 10 OF 1000

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EX-100

ILLINOIS & ILLINOIS RAILROAD CO.

ILLINOIS & ILLINOIS

10 OF 1000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6397

CERTIFICATE OF DEATH

Item 23 Film C288 6/19/61 mh

06381

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Crownsville

c. LENGTH OF STAY IN 1b

9 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Crownsville State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Allen

4. SEX

6. COLOR OR RACE

Male

Negro

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

November 26, 1931

9. AGE (In years
last birthday)

29 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Pollack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

1951 - 1953

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

443X

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause first.

(b)

DUE TO

(c)

Hypertensive Cardiovascular
DiseaseINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Fatty Degeneration of liver assoc. with Alcoholism

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
-----20c. TIME OF INJURY Month, Day, Year
Hour e.m. ----- 19 p.m. -----20d. INJURY OCCURRED
While at work -----20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
-----20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3/13, 19 61 to 6/9, 19 61, that (I) (we) last
saw the deceased alive on 6/9, 19 61, and that death occurred at 12:40 from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Lionel McHenry Mapp, M. D.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
6/9/61

22d. ADDRESS

Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 14, 1961 Baltimore National

23d. LOCATION (City, town or county)

(State)

Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Frances Hensley 578 W. Biadale St.

125a. REC'D BY REGISTRAR
DATE JUN 14 '6125b. REGISTRAR'S SIGNATURE
Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is necessary for the physician to leave the hospital or attending physician may be retained by the physician or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1869

January 1869



W. H. C. & Co.
Manufacturers of
Cotton Goods
and Woolen Cloth
in all
the
various
grades
and
qualities
of
Clothing
and
Household
Linens
etc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6398

CERTIFICATE OF DEATH

06382

1. PLACE OF DEATH

e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Millersville

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Crown Hwy. (Rt. 3-Box 88)

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Millersville

d. STREET ADDRESS

Crown Hwy. (Rt. 3-Box 88)

e. IS RESIDENCE
ON A FARM?YES NO

**3. NAME OF
DECEASED
(Type or print)**

B.

Franklin Pamphrey

Last

Date
OF
DEATH

June

Month

Day

Year
1961

5. SEX

6. COLOR OR RACE

M

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

12 May 1883

9. AGE (In years
last birthday)

76 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

**10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**

Policeman (ret.)

10b. KIND OF BUSINESS OR INDUSTRY

Balto. City Police

11. BIRTHPLACE (County & State, or foreign country)

A.A.C.O., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

B. Franklin Pamphrey Sr.

14. MOTHER'S MAIDEN NAME

Minnie Myers

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or defense service)**

No

16. SOCIAL SECURITY NO.

216-16-2990

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

1 week.

**19. WAS AUTOPSY
PERFORMED?**

YES NO

**20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

**20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)**

20f. (City or town)
(County)
(State)

21. I certify that (I) (this hospital) attended the deceased from June 19, 1957, to June 19, 1961, that (I) (we) last saw the deceased alive on June 20, 1961, and that death occurred at 10PM, from the causes and on the date stated above.

22a. SIGNATURE

C.R. McDonald MD

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.22b. DATE
SIGNED

**22c. PHYSICIAN'S
NAME (Type)**

C.R. McDonald,

22d. ADDRESS

Glen Burnie, Md. 6/28/61

**23a. BURIAL, CREMATION,
REMOVAL (Specify)**

23b. DATE THEREOF

Cedar Hill Cem.

23c. NAME OF CEMETERY OR CREMATORIUM

Bklyn-PED, NY

23d. LOCATION (City, town or county)

Bklyn-PED, NY

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

R.Y. Singleton

ADDRESS

Glen Burnie, Md.

25e. REC'D BY REGISTRAR

Arthur S. Kline

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

35531

M

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Film 289
6-23-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6399

06383

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Anne Arundel MARYLAND		e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1 511 Ludlow Road	
3. NAME OF DECEASED (Type or print)		First	Middle
Sadie			ROSENSTEIN
3. NAME OF DECEASED (Type or print)		Last	4. DATE OF DEATH
Sadie		June	14 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years least birthday) IF UNDER 1 YEAR 69 yrs. Months Days Hours Min.
		own home	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
A. Kasakow		? Kasmacrsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
no no		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbovascular Thrombosis</i>			
888.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ceremia + hypertension</i>			
3 days			
DUE TO (c) <i>Overdose of dicumarol, accidental</i>			
2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes mellitus; generalized arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Patient took 3 dicumarol tablets daily instead of 1 2 digoxin (the digoxin bottle contained dicumerol - error has not been explained) (State)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
June 19 61			Annanolis Md
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from June 11, 1961, to June 14, 1961, that death occurred at M, from the causes and on the date stated above.			
22e. SIGNATURE <i>John L. Hedeman</i>			
M.D.			
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
22e. PHYSICIAN'S NAME (Type) John L. Hedeman			
23b. DATE THEREOF Burial June 16, 1961			
23c. NAME OF CEMETERY OR CREMATORIAL Hebrew Friendship			
23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home			
ADDRESS Annapolis, Md.			
25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUN 19 '61 Arthur S. Kraus			

9830

9830



John C. Smith

Smith

John C. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If you are unable to do so, you may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1
a. PLACE OF DEATH
b. COUNTY

6400

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Tressie

4. DATE
OF
DEATH

June

13

19 61

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

DEC. 9, 1920

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Johnathan Nelson

14. MOTHER'S MAIDEN NAME

MINNIE

VAN METER

Address

ABOVE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

GEN Roy

INTERVAL BETWEEN
ONSET AND DEATH
48 hr.

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

587.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

acute pancreatitis

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) attended the deceased from.....

June 11, 1961, to.....June 13, 1961, that (I) last

saw the deceased alive on.....

June 13, 1961, and that death occurred at.....M, from the causes and on the date stated above.

22a. SIGNATURE

J. Borssuck

M.D.

7:22 A.M.

ATTENDING MED.

PHYS. DIRECTOR STAFF PHYS. 22b. DATE
SIGNED

6/13/61

22c. PHYSICIAN'S
NAME (Type)

Samuel Borssuck

22d. ADDRESS

Amos Garrett Blvd., Annapolis, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

6-16-61

23c. NAME OF CEMETERY OR CREMATORIAL

BALTO. NATIONAL

23d. LOCATION (City, town or county)

BALTO. MD

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

F. J. Borssuck

ADDRESS

SEVERNA PK.

25e. REC'D BY REGISTRAR

DATE JUN 16 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraas

12610

Johnson 1911

1911

Johnson 1911

10

Miner - Larva

1911

Johnson

Brown - Larva

Johnson Larva found on

Le. 5. 1911

TON

slight

15 miles

Johnson

1911

126

Le. 5. 1911

1911

Johnson Larva found on

Johnson Larva

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6405

CERTIFICATE OF DEATH

06383

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 200 King George St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle BELLAMY	Last ST GEORGE
4. DATE OF DEATH June 18 1961	Month June	Day 18	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM St GEORGE		14. MOTHER'S MAIDEN NAME ISABELLE WESCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. I + II	
17. INFORMANT Ela R. St George		Address ②	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 163X		INTERVAL BETWEEN ONSET AND DEATH 1+yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) John M. Taylor attended the deceased from June 17, 1961 , to June 17, 1961 , that (I) John M. Taylor last saw the deceased alive on June 17, 1961 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 6.20.61	
22c. PHYSICIAN'S NAME (F.R.E.) FRANK M. SHIPLEY		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 7:05 A.M.	22d. ADDRESS 121 Cathedral St., Annapolis, Md.
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-1961	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Son		ADDRESS Annapolis Md	25e. REC'D BY REGISTRAR DATE JUN 21 '61
			25b. REGISTRAR'S SIGNATURE Charles S. Kraus

28600

601A

LAWRENCE

BROWN

DEPARTMENT OF STATE

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RECORDED BY TELETYPE UNIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6401

CERTIFICATE OF DEATH

06385

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 825 Bay Ridge Ave.,	
3. NAME OF DECEASED (Type or print) James		4. DATE OF DEATH Last SERGEANT Month June Day 15 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1884	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY Butler	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) Unknown		16. SOCIAL SECURITY NO. 17. INFORMANT Minnie S. Sargeant #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CEREBRAL HEMORRHAGE DUE TO (c) HYPERTENSIVE CARDIO-VASCULAR DISEASE			
INTERVAL BETWEEN ONSET AND DEATH 40 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <input type="checkbox"/> attended the deceased from..... June 11, 1961 to..... June 15, 1961 , that (I) <input type="checkbox"/> last saw the deceased alive on..... June 14, 1961 , and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5:35 A.M.	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-61	
23c. NAME OF CEMETERY OR CREMATORIAL St. Marys		23d. LOCATION (City, town or county) Annapolis (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Pugh, Son, Annapolis, Md.		ADDRESS 25a. REC'D BY REGISTRAR DATE JUN 19 '61	
		25b. REGISTRAR'S SIGNATURE Charles L. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06386

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

5 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Thomas

Lawrence

SEGER

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Thomas Edward Seger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

14. MOTHER'S MAIDEN NAME

Dorothy Ellen Jackson

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Penicillity

INTERVAL BETWEEN
ONSET AND DEATH
4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) attended the deceased from May 31, 1961, to June 5, 1961, that (I) last saw the deceased alive on June 5, 1961, and that death occurred at M, from the causes and on the date stated above.

8:10 A.M.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 7, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

Ft Lincoln Cemetery

23d. LOCATION (City, town or county)

Colmar Manor, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Gasch's Sons Hyattsville Md.

ADDRESS

25e. REC'D BY REGISTRAR

DATE JUN 8 '61

25b. REGISTRAR'S SIGNATURE

Calling S Thomas

M

febbraio anno

stampa

magli

informa

L'anno scorso

l'anno scorso l'anno scorso

Io

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un

l'anno scorso

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scritto - fatto

Io sono

un

l'anno scorso

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6403

CERTIFICATE OF DEATH

06387

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		10 Annapolis d. STREET ADDRESS 10 Monticello Ave.	
3. NAME OF DECEASED (Type or print) THOMAS JOHN SLAFKOSKY		4. DATE OF DEATH JUNE 4 19 61	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Dec. 4, 1959	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months 6 Days 6 IF UNDER 24 HRS. Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) none Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME A. Leonard Slafkosky	
14. MOTHER'S MAIDEN NAME Margaret Mary Euff		15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. Address	
17. INFORMANT (Yes, no, or unknown) (If yes, give name and date of service)		no none Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspergillus Pneumonia with Alveitis 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO see to Cerebral Circum Depet (c)	
		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from BIRTH, 19 61, to 6/4, 19 61, that (I) (we) last saw the deceased alive on 6/4, 19 61, and that death occurred at 11 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 6/8/61	
22a. SIGNATURE Philip Briscoe M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Philip Briscoe		22d. ADDRESS Cathederal Street, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 6, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE JUN 8 '61			

850

803

new addition to the library. The new addi-

tion will be located in the rear of the building.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6404

06388

CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		Anne Arundel		MARYLAND		a. STATE		Maryland		b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				Anne Arundel					
Annapolis				5 days									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?					
Anne Arundel General Hospital				Rt-6, Box-160				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH		Month	Day	Year			
Samuel		S.		SPRINKEL		June		22	19	61			
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR			
Male		White		WIDOWED		Divorced		52 yrs.		Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)					
sewerage plant				Balto. City,				Maryland					
12. CITIZEN OF WHAT COUNTRY?													
U.S.													
13. FATHER'S NAME													
Samuel S. Sprinkel													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address	
yes				216-10-7509				Nona B. Sprinkel Rt. 6 Pasadena, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary edema													
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial infarction due to													
DUE TO } (c) Coronary thrombosis													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
Lobar pneumonia													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m.				Month, Day, Year		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, straat, officia bldg., etc.)		20f. (City or town)		(County)	(State)
19													
21. I certify that (I) attended the deceased from..... June 17, 1961, to..... June 22, 1961 that (I) last saw the deceased alive on..... June 22, 1961, and that death occurred at..... M, from the causes and on the date stated above.													
7:25 A.M.													
22a. SIGNATURE													
Arthur Lankford Jr. M.D.													
22c. PHYSICIAN'S NAME (Type)													
Arthur Lankford, Jr.													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORI				23d. LOCATION (City, town or county)	
Burial				6/26/61				Baltimore National Cem.				Baltimore, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE													
Howard H. Hubbard 4107 Wilkens Ave.													
ADDRESS													
25a. REC'D BY REGISTRAR													
DATE JUN 26 '61													
25b. REGISTRAR'S SIGNATURE													
Arthur S. Kraus													
VR A15 (4) 15M 9/60													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06390

1. PLACE OF DEATH e. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Md		b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Crownsville		c. LENGTH OF STAY IN 1b 1 year, Two 5 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Crownsville State Hospital		d. STREET ADDRESS 1610 2nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle	Last TAYLOR	4. DATE OF DEATH	Month 6	Day 3	Year 1961
5. SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/1928		9. AGE (In years at birthday) 35 yrs. IF UNDER 1 YEAR Months Dey Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOE B. TAYLOR				14. MOTHER'S MAIDEN NAME CATHERINE GRACE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Pulmonary Infarctions of unknown origin (c) DUE TO Bronchopneumonia with								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Mental Deficiency								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 10/28, 1959 to 6/3, 1961 (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/28, 1959 to 6/3, 1961, that (I) (we) last saw the deceased alive on 6/3, 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.								
22e. SIGNATURE Carl B. Schleifer		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED June 4, 1961		
22c. PHYSICIAN'S NAME (Type) Carl B. Schleifer, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland						
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 JUNE 61		23c. NAME OF CEMETERY OR CREMATORIAL BREWER Hill		23d. LOCATION (City, town or county) ANNAPOLIS, A.A. Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE James H. Johnson		ADDRESS Pleasant St. ANNAPOLIS, MD.		25e. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Charles E. Thomas		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dep't. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AP 1
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
6407						CERTIFICATE OF DEATH								
						06391								
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY			a. STATE											
Anne Arundel			Maryland											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			b. COUNTY											
Annapolis			Anne Arundel											
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
			RURAL - Annapolis											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS											
Anne Arundel General Hospital			Pendennis Mount											
First Middle Last			4. DATE OF DEATH											
William M. THOMAS			June 18 1961											
5. SEX			5. COLOR OR RACE			6. MARRIED			7. NEVER MARRIED			8. DATE OF BIRTH		
Male			White			<input checked="" type="checkbox"/>			<input type="checkbox"/>			April 29, 1878		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
LUMBER BUSINESS			LUMBER HARDWARE			Pennsylvania			U.S.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME											
John M. Thomas			EMMA KENDRICK											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
(If yes, give war or dates of service)			-			NANCY B. THOMAS			(2)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
331X DUE TO <i>Azotemia</i> 3 wks.														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebro-Vascular Hemorrhage</i> 9 wks.														
DUE TO (c) <i>Arterio sclerosis; Generalized</i> 1 mo.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m.			Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) attended the deceased from..... 5-13-1961 to..... 6-18-1961, that (I) (wrote last saw the deceased alive on..... 6-18-1961, and that death occurred at 1 AM, from the causes and on the date stated above.														
22a. SIGNATURE <i>James R. Martin</i>			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS 6 Shaw St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/20/1961			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemt			23d. LOCATION (City, town or county) Washington DC					
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>			ADDRESS Annapolis Md.			25e. REC'D BY REGISTRAR DATE JUN 21 '61			25b. REGISTRAR'S SIGNATURE <i>Charles S. Thoms</i>					
VR A15 (4) 15M 9/60														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G288 6/12/61 1wk
 6408 CERTIFICATE OF DEATH

Reg. Dist. No.

06392

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL - Rt 2</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <i>MILLERSVILLE-Box 35</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>	
d. STREET ADDRESS <i>MILLERSVILLE-Box 35</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Richard</i>	Middle <i>-Wesley</i>	Last <i>Tonduz</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>2</i>	Year <i>1961</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9-10-1899</i>
9. AGE (In years lost/birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STATE OF MD. Roads Comm. Laborer - A.A. Co. Md.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Alverta A. Tonduz - Rt. 2 Millersville</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address Box 35</i>	
13. FATHER'S NAME <i>ELI Tonduz</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA Johasoy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-16-3470</i>	
17. INFORMANT <i>Alverta A. Tonduz - Rt. 2 Millersville</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Bilateral</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Cerebral Vascular accident</i>		26 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>H.S. & V.D.</i>		>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i> </i>	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>61</i> , to <i>May</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>6-1-61</i> , 19 <i>61</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Felix Greelle</i>		ADDRESS (Street, city or town, state) <i>609 Odenton Rd</i> DATE SIGNED <i>6/3/61</i>	
PHYSICIAN'S NAME (Type) <i>Febus Gruber</i>		M.D. <i>Odenton Md -</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-5-61</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Chew's Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>A.A. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Hicks III ANNAPOLIS-Md.</i>		ADDRESS DATE JUN 7 '61	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Charles S. Knott</i>	

BRUNNEN Verlag - Ein Teil der BILD-Kommunikationsgruppe

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06393

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>	
3. NAME OF DECEASED (Type or print) <i>LUGINA</i>		d. STREET ADDRESS <i>Ridge Road</i>	
4. DATE OF DEATH <i>JUNE 1 1961</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-19-1880</i>
9. AGE (In years from birthday) <i>80</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Pete Hudson</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Glenn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Getrude Harris</i>	
17. INFORMANT <i>Address Ridge Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Thrombosis</i>			
DUE TO (c) <i>Generalized Arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Winter</i>		20f. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>5-31</i> , 19 <i>59</i> , to <i>5-31</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>5-31</i> , 19 <i>61</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Jose M. Yosuico, M.D.</i>		ADDRESS (Street, city or town, state) <i>Tessup, Md.</i> DATE SIGNED <i>6-1-61</i>	
PHYSICIAN'S NAME (Type) <i>Jose M. Yosuico, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/5/1961</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Calvary Cemetery</i>		22d. LOCATION (City, town, county) <i>Oliver Hill Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i>		24a. REC'D BY REGISTRAR <i>Schroeder List</i>	
24b. REGISTRAR'S SIGNATURE <i>Cynthia S. Hayes</i>		DATE JUN 5 '61	

WYOMING STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MAXWELL

STACI
HORN

D. M. D.

DECEASED PERSON'S NAME

MAXWELL,
STACI HORN

Date of Death

NAME OF DECEASED PERSON

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06395

FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C.	
b. CITY OR TOWN (if outside corporal limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb 30 y.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) District Training School, Pine Cottage,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell Windlund		First	Middle
4. DATE OF DEATH june 29th	Month June	Day 29	Year 1961
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Children's Center Records, Laurel.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO } (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 6/30/61	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 6/30/61		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS District Training School	
23. FUNERAL DIRECTOR John J. Hoone Jr. DTS Laurel		22d. LOCATION (City, town, or country) (State) Laurel Maryland	
		24a. REC'D BY REGISTRAR DATE JUL 7 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06394

Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Pasadena

c. LENGTH OF STAY IN 1b

20 y.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

294 Magothy Beach Rd.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Walter Lee Woods

4. DATE
OF
DEATH

June 23rd.

19 61

5. SEX

6. COLOR OR RACE

M

C

7. MARRIED NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

DIVORCED

10/15/08

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

52 rs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Laborer

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
Address

Howard Woods, (son) 247 Hanover St. Annapolis, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

6/23/61

DATE SIGNED

Address (Street, city, town, or county)

Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 22d. LOCATION (City, town, or county) (State)

Burial 6-27-61

Magothy Cen Anne Arundell Cen

Choy O. Wilson 1000

Monetary Ave.

24a. REC'D BY REGISTRAR JUL 10 '61

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06396

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Geo G Meade,		c. LENGTH OF STAY IN lb 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY Hospital		d. STREET ADDRESS 3305 Round Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First JOYCE	Middle L	Last YOUNG	4. DATE OF DEATH JUNE 18 1961	Month JUNE	Day 18	Year 1961			
5. SEX Female	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7 Jan 1959	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Detroit, Mich		12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME GERALD F YOUNG			14. MOTHER'S MAIDEN NAME Elizabeth Bowman (Mother)		Baltimore, Md					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT (Mother) Elizabeth Bowman	Address 3305 Round Rd					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH 19 Days							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4			Rt Heart failure							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b)			Congenital Heart Disease (Cyanotic) 28 Months							
DUE TO (c)			Subendocardial fibroelastosis (Suspected)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Acute Respiratory Infection										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Arlington	(State) VA	
21. I certify that I attended the deceased from 17 June 1961 , to 18 June 1961 , that I last saw the deceased alive on 18 June 1961 , and that death occurred at 0314 AM , from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) 108 W Montomery										
DATE SIGNED John Clift MD										
ACTUAL SIGNATURE <i>John Clift MD</i>		M.D.								
PHYSICIAN'S NAME (Type) JOHN CLIFT MD										
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/21/61		22c. NAME OF CEMETERY OR CREMATORIAL Cirlington Notes		22d. LOCATION (City, town, or county) Arlington, Va		(State) VA		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ismael J Brown Jr</i>		ADDRESS 108 W Montomery		24a. REC'D BY REGISTRAR JUN 21 1961		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>				
VS A15 (4) 15M 9/55				DATE						

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6413

06397

Items 9 & 11, File 6288 6/9/61

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED

April 20, 1910

Months

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MAINT. SUPERVISOR

10b. KIND OF BUSINESS OR INDUSTRY

U.S. GOVERNMENT

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

OTTO ZACHARIAS

14. MOTHER'S MAIDEN NAME

Hoffbecker

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give rank and dates of service)

No

17. INFORMANT

VELMA P. ZACHARIAS #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Peripheral circulatory collapse.

INTERVAL BETWEEN
ONSET AND DEATH

3 hours.

322.2
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)
Delirium & tremors.

DUE TO

(c)
Neoplasia.

3 days.

Year.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (REMOVED) attended the deceased from June 2, 1961, to June 4, 1961, that (I) (REMOVED) last
saw the deceased alive on June 4, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Gerard Church.

M.D.

2:45 A.M.
ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Gerard Church

22d. ADDRESS

121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county)
BURIAL 6-7-61 Hillcrest Memorial Annapolis Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

170

M